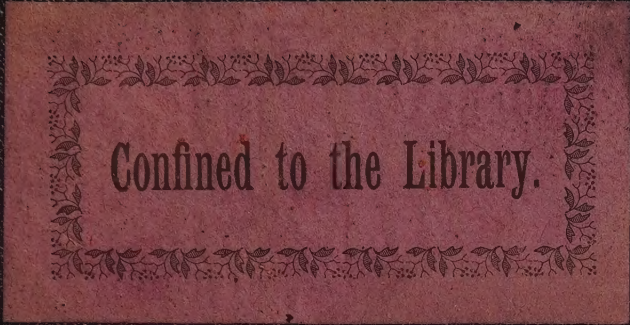




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THE BRITISH JOURNAL
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FOUNDED BY GEORGE CARPENTER, M.D.

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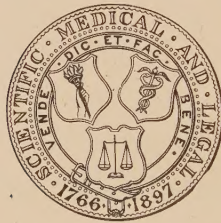
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Original Articles.

PURPURA IN INFECTIVE DIARRHŒA.*

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SYMPTOMATIC purpura in infective diarrhœa of infants has not attracted much attention. Diarrhœa is mentioned incidentally by John Thomson (4) among the cachectic conditions which may cause purpura. As two well-marked examples of extensive purpura in infants semi-comatose as the results of infective diarrhœa happened to come under observation on the same day, we analysed the notes of 100 cases of severe infective diarrhœa with reference to this point. The cases were sufficiently severe to be admitted to the wards of the Victoria Hospital for Children, but otherwise were unselected; about two thirds of them were seen during the past summer. This analysis was made before we had seen Voelcker's paper "On Purpura in Children," (5) in which he comes to much the same conclusions.

* A paper read before the Section for the Study of Disease in Children of the Royal Society of Medicine on November the 24th, 1911.

Of the 100 cases (fifty-six males with an average age of 8 months, and forty-four females with an average age of 7·36 months), sixty-seven (thirty-six males, average age 7 months, thirty-one females, average age 6·2 months) proved fatal, and thirty-three (twenty males, average age 9·4 months, thirteen females, average 10·2 months) recovered. Purpura occurred in eleven (six male, five female) cases, all of which were fatal. Of the sixty-seven cases 16·4 per cent. showed purpura. The average age of the eleven cases was $8\frac{1}{2}$ months, the extremes being 1 month and 28 months. All but two cases (28 months and 12 months) were under 11 months of age; and, exclusive of the girl aged 28 months, the average age works out at 6·2 months. None of the purpuric cases showed œdema: Among the 100 cases there was one case with œdema of the hands and feet which recovered; and two fatal cases (without purpura) showed "septic" rashes.

Site of the purpura.—In one of the eleven cases the situation is not recorded. In eight the eruption occupied the skin of the abdomen, more especially of the lower part, and in four of these the thorax was also affected; in one of the latter there were hæmorrhages on the arms, legs, and head. In one instance the thorax alone was affected, and in another the head only was involved. It is an interesting question why the purpura occurs on the trunk and avoids the extremities where ordinary purpura is more commonly seen. Possibly the absence of the extravasation on the extremities is connected with the exhausted condition of the circulation in these patients, and an extremely low blood-pressure in the peripheral vessels. It is conceivable that with a higher blood-pressure the purpura would be universal. In addition, from the horizontal position of the infants the force of gravity does not favour purpura of the legs as it does in patients who are up. After this paper was read Dr. R. S. Trevor suggested to us that the distribution of the purpura on the lower part of the abdomen might be influenced by the presence and frequent changing of napkins.

Usually the hæmorrhages are small, but they may be so closely set as to make the skin of the abdomen almost uniformly purple when seen from a distance. In a case under the care of Dr. E. I. Spriggs, to whom we are much indebted for its use, there were large hæmorrhages two inches in length on the chest; from the heart's blood of this case Dr. H. R. Dean, of the Lister Institute, isolated *Bacillus enteritidis* Gaertner in pure culture. The average duration of the diarrhœal disease in the cases with purpura was forty-one days, the extremes being two days and eighty days, but in

all except one case the duration was more than two weeks. The purpura was usually a late phenomenon and appeared on an average on the thirty-fourth day, that is, a week before death. It is therefore connected with cachexia rather than acute infection or toxæmia. Though usually seen shortly before death, in one instance six hours before, the purpura is not always terminal: in one patient the rash disappeared and the child improved, but the diarrhœa returned and proved fatal two weeks after the eruption had vanished. In another case there were three crops of purpura, seventeen, eight and two days before death respectively.

Special note was taken to see if transfusion or the administration of horse or other serum could have had any influence in causing the purpura. But in most instances the appearance of the purpura preceded transfusion or the use of serums.

Our cases do not suggest any close relation between purpura and the œdema which sometimes occurs in children after gastro-enteritis (Fairbanks (2), Dewolf (1), Hume (3), and others). It would not be unreasonable to suppose that if intestinal toxæmia gives rise to œdema a more severe toxæmia would induce hæmorrhages, and that a case might first show œdema and later purpura as the toxæmia became progressively more severe. The suggestion that purpura is due to a hæmic infection is attractive, but we have little proof to offer, as bacteria were only found in the blood in one case—that mentioned above. In one case only was there evidence of infantile scurvy. Our notes do not justify any expression of opinion on the question whether or not renal insufficiency plays any part in the production of purpura.

Prognosis.—As judged by our eleven cases of purpura, all of which were fatal, the prognosis is extremely grave. Voelcker, however, says that it is by no means necessarily a fatal sign, and the events already described in two of our cases suggest that recovery might occur.*

CONCLUSIONS.

- (1) Symptomatic purpura in infective diarrhœa mainly occurs on the abdomen and chest of infants under the age of one year.
- (2) It is usually a terminal phenomenon in prolonged cases.
- (3) The prognosis in these cases is extremely grave.

* In a case which came under observation after this paper was written, recovery occurred after a single hæmorrhage, the size of half-a-crown, had appeared under the skin of the abdomen between the umbilicus and the pubes.

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MORTALITY AND MORBIDITY IN HEREDITARY SYPHILIS.

By C. F. MARSHALL, M.D., F.R.C.S.,
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THE mortality and morbidity resulting from the transmission of syphilis from parents to offspring were studied some years ago by Fournier; more recently Hochsinger and Leroux have added important contributions to our knowledge of this subject.

Fournier's statistics, based chiefly on cases observed in private practice, were as follows:

	Mortality.	Morbidity.
Paternal transmission	28 per cent.	37 per cent.
Maternal "	60 "	84 "
Mixed "	68·5 "	92 "

The mortality and morbidity thus vary approximately in the same ratio, but differ according to the origin of the disease, being least in congenital syphilis of paternal origin, greater in that of maternal origin, and greatest when the disease is transmitted by both parents.

Leroux has recently published the results of his observations on heredo-syphilis at the Furtado-Heine Dispensary, Paris. His statistics of mortality are approximately the same as those of Fournier.

Syphilitic heredity manifests itself in four ways: (1) In the form of polymortality (foetal, early or late); (2) as virulent or active heredo-syphilis (early or late); (3) as dystrophic heredo-syphilis, or heredo-parasyphilis; (4) as syphilitic heredity without symptoms.

These manifestations differ somewhat according to the origin of the disease, whether paternal, maternal or mixed, but more considerably according to the age of the disease.

Differences according to origin of disease.—(1) Paternal transmission more often gives rise to late heredo-syphilis and heredo-para-

syphilis than to virulent early heredo-syphilis, although the latter occurs when the disease in the father is recent; but the duration of virulence is shorter in the father than in the mother. Paternal transmission gives rise to more healthy infants. (2) Maternal transmission, on the other hand, causes more cases of virulent heredo-syphilis and the virulence diminishes more slowly than in the case of paternal syphilis. Heredo-parasyphilis is less common. In both paternal or maternal syphilis virulent and dystrophic symptoms may be present at the same time. (3) In mixed transmission polymortality is more frequent and prolonged, virulent symptoms generally more severe, and heredo-parasyphilis more common than in pure maternal transmission.

Differences according to age of disease.—It is obvious that the more recent the disease in the parent or parents, the more frequent are virulent manifestations likely to be in the offspring. The first-born generally suffer from virulent heredo-syphilis, later children from late heredo-syphilis or parasyphilis. However, transmission of the disease varies both in nature and intensity in different pregnancies. Healthy or only slightly affected children sometimes alternate with others who are profoundly affected—a fact which is difficult to explain.

The age of the parental disease explains the greater virulence of heredo-syphilis of maternal origin. Maternal syphilis is generally more recent than paternal; hence the former causes more virulent heredo-syphilis and the latter more dystrophic phenomena, or parasyphilis.

Effect of treatment.—The influence of treatment is another factor in the greater virulence of heredo-syphilis of maternal origin, for while the father usually receives treatment before marriage, the mother, if she contracts syphilis, is frequently untreated owing to ignorance, neglect, or both.

As regards the effect of treatment on the offspring, most cases of active heredo-syphilis, both early and late, can be cured by mercurial treatment, but this treatment should be prolonged for two years at least. It is bad practice to treat congenital syphilis during the presence of symptoms only. This is often due to the incomplete education of the doctor in syphilology, but more often, perhaps, to the neglect of parents. On the other hand, the dystrophies of heredo-syphilis, or parasyphilitic phenomena (including many incurable nervous and mental affections), are not influenced by mercurial treatment.

Hochsinger gives the following statistics of cases treated at the

Children's Hospital, Vienna, and followed up for several years afterwards. Out of 516 births of syphilitic infants 253 were born dead or died soon after birth. Of the 263 which survived, 55 died before the age of four years in spite of specific treatment. Of the 208 remaining, 51 remained healthy. Hochsinger hence concludes that only about 25 per cent. of syphilitic infants grow up into comparatively normal adults. As regards treatment, he finds that relapses in the children are rare during the first year of life when the parents are submitted to intensive treatment.

In order, therefore, to effect the cure of syphilitic heredity it is necessary to treat the parents. The chief difficulties are ignorance and neglect. A man who has had syphilis should not marry till he has undergone at least two years' treatment, and even then only when two years have elapsed without symptoms. If this is impossible he should continue treatment after marriage. If the wife becomes infected she must be treated during the whole of pregnancy, and during subsequent pregnancies if the first child shows signs of syphilis. Any child showing signs of congenital syphilis at or soon after birth should be treated for two years. It is probable that if all syphilitic infants received such prolonged treatment we should see less of the signs of late heredo-syphilis and parasyphilis. By such means, if the parents can be sufficiently educated to realise the gravity of the situation and the importance of prolonged mercurial treatment, syphilitic heredity may be modified, attenuated, or even extinguished.

Unfortunately the public have recently been "educated" in the wrong direction, owing to the blatant advertisement in the lay press and elsewhere of a new drug (salvarsan, or "606"), which was stated to cure syphilis in one or two doses. It is now well known that this drug has not fulfilled its expectations, and there is no proof that it cures syphilis. On the other hand, it has caused many deaths, some in healthy persons, and on this account Hallopeau and others recommend that its use should be abandoned, like that of atoxyl and arsacetin. Other authorities regard it as useful in certain cases which do not react to mercury and iodides, but, as Gaucher remarks, such cases are very rare.

Nearly all authorities now recommend the usual prolonged mercurial treatment in addition, so that we may well ask why the older preparations of arsenic such as Donovan's solution, which are free from danger, should be abandoned in favour of a drug which may cause the death of healthy persons.

There is little doubt that, owing to the manner in which the

public have been misled by premature reports of cures by salvarsan, many persons infected with syphilis have abandoned prolonged mercurial treatment and have suffered in consequence. Instead of realising the Utopian idea of banishing syphilis from the face of the earth, it is highly probable that salvarsan has caused an appreciable increase both in the amount and severity of that disease.

It is to mercury that we must look for the cure of syphilis and syphilitic heredity. In the present state of our knowledge there is no short cut to salvation by a few injections of salvarsan or any other drug, nor is it likely that such a chronic infection as syphilis can thus be jugulated.

Postscript.—It will be noticed that in this article the occurrence of pure paternal syphilis by spermatic infection of the ovum has been assumed. As this is a view which has been much controverted, especially since the discovery of the spirochaeta and the Wassermann reaction, I hope to deal with it in a subsequent article.

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A CASE OF MYATONIA CONGENITA.

By J. R. CHARLES, M.A., M.D., M.R.C.P.,

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THE disease myatonia congenita is sufficiently rare to make the following case worth recording.

The patient is a boy, aged 6 years. There is nothing of importance in the family history. No history of consanguinity. The boy is the eldest of the family. There are four other children, three of whom are healthy; one is said to have a gland in his neck. There is no history of any nervous disease, insanity or epilepsy in the family, or any condition similar to this. The patient was a full-term child; the health of the mother during pregnancy was good. Fœtal movements were felt during pregnancy. The labour was normal; no forceps were used. There was no rash or snuffles at birth. A congenital inguinal hernia was present on both sides.

The present condition of muscles and hands has been in existence from birth.

He cut his first tooth at three months and began to walk and

talk when two years old. He had a few convulsions when cutting his teeth. He was breast-fed for nine months and then put on patent foods. He has had no illnesses from birth till the present time. He has a good memory, is usually good tempered, sleeps well, plays with other children normally, and is well developed intellectually for his age.



FIG. 1.

The special senses, speech and articulation are all normal. There is no evidence of any involvement of any of the muscles supplied by the cranial nerves. No myopathic facies.

There is the extreme atonic condition of the muscles of the arms and legs and to a less extent those of the trunk. He sits in bed with a certain degree of kyphosis, but can straighten his back if he tries. There is considerable weakness in all the muscles of the arms, this being most marked in the distal parts. The laxity

of muscles and ligaments around the wrist-joints allows a partial dislocation. The hands and fingers are extremely flail-like, and can be bent backwards and forwards into grotesque positions (Figs. 1 and 2). The grip is fair. There is no fibrillation. When



FIG. 2.

lying on his back he can raise himself into a sitting posture without the use of his arms.

The diaphragmatic movements appear good. A condition exists in the legs very similar to that in the arms. The same flail-like condition is noted. Partial dislocation of the knee-joints is easily obtained. The atonic condition is again most marked in the distal

portions of the limbs. Owing to the laxity of the muscles around the feet these are completely flattened, and the weight of the body is not borne by the heel but by a point some one and a half inches anterior to this (Fig. 3).

He can walk with a waddling gait on a broad base.

There is no reaction of degeneration in any of the affected muscles, but faradic irritability appears slightly diminished in some. The triceps jerks are not obtained; the wrist-jerks can be

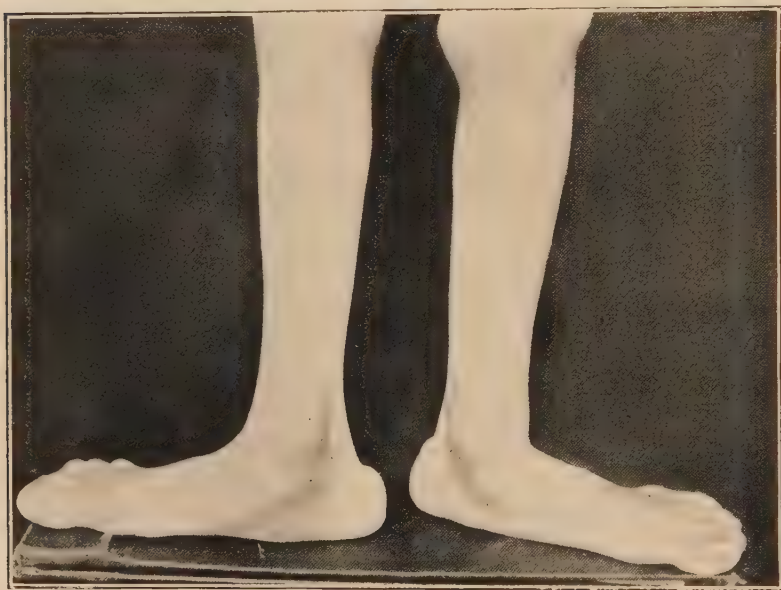


FIG. 3.

elicited; the knee-jerks are present; plantar reflexes flexor. Sphincters normal; sensory system normal.

The cranium is large, the forehead high, and there is some elongation of the head. Antero-posteriorly there appears to be considerable bony thickening along the line of the sutures; this, however, is not obvious in a skiagram. There is nothing of any importance to record in the condition of the heart, lungs, or in the abdomen.

There is no lymphatic enlargement. The thyroid gland is not enlarged. Although the head is large, there are no evidences of rickets in the thoracic or other bones.

This case manifests practically all the characteristics of myatonia congenita in a mild form.

Collier and Holmes thus describe the main points of the complaint, contrasting it with the myopathies:

(1) An absence of familial tendency.

(2) An absence of any familial ætiological relation with the myopathies.

(3) The disease is almost always congenital, but in a small minority of cases it appears suddenly and in fully developed form after certain acute illnesses.

(4) The local wasting and weakness of an individual muscle, or of a group of muscles, which is characteristic of all forms of myopathy, is not met with in myatonia congenita.

(5) The affection of the periphery of the limbs, and especially of the intrinsic hand muscles, is the invariable rule in myatonia (and the greatest rarity in myopathies).

(6) Myatonia never spreads to regions previously unaffected. Slow spreading is characteristic of myopathies.

(7) The deep reflexes are absent from the first in myatonia. In myopathy they are present at first and then slowly diminish, and are lost as the affection of the muscles concerned increases.

(8) The deep reflexes may appear in myatonia when improvement occurs, and, having appeared, remain permanently. In myopathy the deep reflexes never reappear after disappearance.

(9) Some of the recorded cases of myatonia have shown a tendency to improve progressively, and thus improvement may reach a stage of practical recovery.

F. E. Batten, in a critical review of the myopathies, calls into question many of these points of contrast, and incidentally remarks that in many cases of myatonia the condition has been one of progressive deterioration.

The marked hypertonicity of the muscles seems, however, to be a feature definitely separating the condition from myopathy, a view which is favoured by French writers.

Up to the present there have not been many autopsies in these cases. In one case no change was found in the central nervous system.

In some cases, however, the motor cells of the ventral horns have been much reduced in number, appearing in one case to be scarcely a third of the normal number of cells, while those which were present were smaller, more angular and more irregular than normal. The ventral roots were smaller than normal.

The muscles may be partially replaced by fat, and contain a considerable excess of fibrous tissue. Some of the muscle-fibres have been found normal, but many of the fibres have been extremely small. Transverse striation was well marked in them. A few of the fibres have been of enormous size (measuring 100 to 150 μ in diameter). Some of the large fibres have been seen on longitudinal section to be splitting into apparently well-formed fibres of small calibre provided with a normal sarcolemmal sheath and nuclei. A few were vacuolated, and some contained central nuclei. There was a thickening of the walls of the blood-vessels by a periarteritis and some proliferation of the internal cells. Changes in the thymus and thyroid have been described, but as these changes gave rise to no clinical evidence of their presence during life, and as similar changes have been absent in other cases, it is probable that their presence was fortuitous.

I have to thank Mr. James Taylor, who is in charge of the X-ray Department of the Bristol Royal Infirmary, for the excellent skiagrams and photographs which he has kindly taken of this case.

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DIPHTHERIA OF THE ŒSOPHAGUS.*

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A BOY, aged 2 years and 4 months, was admitted moribund to the Grove Fever Hospital on October the 14th, on the eleventh day of disease, and died in seven hours. No antitoxin had been given, diphtheria not having been diagnosed until the day of admission.

Condition on admission.—Profound toxæmia, pulse imperceptible, temperature 97·6° F. Old membrane visible on tonsils, uvula and epiglottis. Pronounced oral foetor, profuse blood-stained nasal discharge. Upper part of right ear swollen and excoriated.

* Specimens of the case were shown at the Section for the Study of Disease in Children of the Royal Society of Medicine, on October the 27th, 1911.

Sloughing wound just below left external malleolus. Cultures of the throat, ear, and wound all showed numerous Klebs-Loeffler bacilli.

At the necropsy the tonsils, pillars, uvula, pharynx, epiglottis, aryepiglottidean folds, and interior of larynx showed remains of membrane or varying degrees of necrosis. The loss of substance was most marked in the aryepiglottidean folds and in the left side of the pharynx in which part of the mucous membrane was destroyed and the muscular wall exposed. The mucosa lining the



Diphtheria of the œsophagus. (From a drawing by M. E. Waring.)

arytenoid and thyroid cartilages showed only minute and superficial areas of ulceration. The trachea was normal.

The œsophagus in its upper third was apparently normal, the middle third presented some injection of the mucosa, and in the lower third were two longitudinal areas of necrosis, 3.5 cm. each in length, coalescing below, where they measured 2.2 cm. in width, and stopping just short of the lower end of the œsophagus (*vide* Fig.). In the centre of one of the areas the muscular wall was exposed. No diphtheritic membrane was left, but direct smears and cultures from the necrotic areas showed numerous diphtheria bacilli.

Histological examination showed destruction of the epithelium, engorgement of the vessels, and considerable round-celled infiltration in the submucous layer extending into the muscular coat. The stomach was normal. The heart and kidneys showed some fatty change, and there were some hæmorrhages in the mesentery. No lesions in the other organs were found.

Involvement of the œsophagus in diphtheria is a rare event. When it does occur it is usually associated with multiple lesions elsewhere, as in the present case, in which the fauces, nostrils, pharynx, larynx and skin were also affected. The condition cannot be diagnosed during life except by expulsion of a cast of the œsophagus, or by subsequent development of œsophageal stricture in cases which survive. As a rule, as in this case, it is a necropsy surprise.

The Museum of the Royal College of Surgeons has hitherto contained only two specimens of the kind, the one presented by Dr. Goodhart in 1875 (No. 2292 in Catalogue), and the other by Dr. E. W. Goodall in 1896 (No. 2292A). The specimens of the present case have since been added.

On the other hand, it is probable that if a systematic examination of the œsophagus was made post mortem in every case of diphtheria, membrane would be found more frequently in this situation. Thus among 251 necropsies in diphtheria cases reported by Mallory, definite membrane was found in the œsophagus in twelve cases, or 4·7 per cent. The literature of the subject shows that the diagnosis of diphtheria of the œsophagus was much more frequently made in the pre-bacteriological era than at present, often, indeed, on purely clinical grounds, such as difficulty of swallowing or vomiting, as in cases reported by Greenhow, Burdon Sanderson and Gull. My own case had great difficulty in swallowing, but not more than is usually found in severe faucial and laryngeal diphtheria.

Although post-mortem evidence was present in the cases reported by such well-known authorities as Bretonneau, Bristowe, Jacobi, Jenner, Morell Mackenzie, and Sanné, who may be accredited with a correct diagnosis in spite of the absence of bacteriological confirmation, it is not improbable that some of the early cases in which membrane was found in the œsophagus at the necropsy were due to the action of concentrated hydrochloric acid, which was once much in vogue for the local treatment of diphtheria.

In some of the other cases the disease may have been not diphtheria but scarlet fever, in severe forms of which œsophageal necrosis is an occasional sequela. Thus in a series of 128 scarlet

fever necropsies œsophageal ulcers were found in fifteen cases (Oppikofer).

H. D. Fry, of Washington, in 1885 collected fourteen cases of diphtheria of the œsophagus, including one of his own. In seven diphtheria was the primary disease, and in seven it was secondary to scarlet fever, pneumonia, tuberculosis, or other diseases. The membrane involved the œsophageal mucosa either as a tubular lining, or in bands prolonged to the cardia in seven cases. Only two of the fourteen expelled an œsophageal cast.

Since the publication of Fry's paper, which appeared prior to the general recognition of the diphtheria bacillus, I can find records of only eight cases, exclusive of those reported by Mallory. In five the diagnosis was established on bacteriological grounds and post-mortem findings (Goodall, Cautley, Fawcett, Leathem, Field), only one of which (Field's case) expelled an œsophageal cast before death, and in three which recovered the diagnosis was based on the presence of an œsophageal stricture which developed shortly after an attack of diphtheria (Korczynski, Jungnickel, Danielsen). In Korczynski's case perforation of the œsophagus occurred, as shown by the sudden appearance of surgical emphysema in the neck. In Cautley's and Leathem's cases membrane was also found in the stomach post mortem, and in Korczynski's case the frequent hæmatemesis and persistent pain in the epigastrium suggested a gastric ulcer of diphtheritic origin.

A striking feature in the present case was the marked destruction of tissue which was found, not only in the œsophagus but also in the pharynx. Although neither of the specimens already alluded to in the Royal College of Surgeons' Museum shows any such changes, necrotic lesions in the œsophagus have been met with in other cases and are due to secondary infection, especially by cocci (Danielsen). It is readily conceivable that had my case recovered, cicatrisation of the lesions would have led to stricture. Post-diphtheritic stricture of the œsophagus, though an extremely rare occurrence, has been recorded in the pre-bacteriological era by Gendron, Leube and Penzoldt, and Trendelenburg, and more recently by Korczynski, Jungnickel, and Danielsen. In all the cases recovery followed gradual dilatation of the stricture by bougies. In some of the cases, especially those reported by the earlier writers, the obstruction to the passage of food may have been due to diphtheritic paralysis, but in others an undoubted cicatricial stenosis, sometimes multiple, existed, for which no other cause than diphtheria could be discovered.

The localisation of diphtheria in the œsophagus in the present case is difficult to explain, especially as there was no history of tube feeding or of the passage of bougies. In children already suffering from œsophageal stricture as the result of swallowing lye, an attack of diphtheria is apt to be very severe. Jacobi and Baginsky have each recorded fatal cases. The œsophageal cicatrices in both these cases were invaded by diphtheritic membrane, the frequent use of bougies having predisposed the stricture to infection.

In my own case the œsophagus was probably affected by the diphtheritic process at an early stage of the disease, as the membrane had entirely separated at the necropsy.

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A CASE OF ACUTE PURULENT ARTHRITIS IN A CHILD
OF TEN MONTHS, WITH RADIOGRAPH.

By J. BURFIELD, F.R.C.S.Eng.,
Hon. Assistant Surgeon, Norfolk and Norwich Hospital; and

A. J. CLEVELAND, M.D., M.R.C.P.,
Hon. Assistant Physician, Norfolk and Norwich Hospital.

A BOY, aged 10 months, was seen by one of us (J. B.) on August the 14th, 1911, for pain in the left thigh. For some three weeks he had had whooping-cough, but was not unusually ill with it. Within the last day or so the mother had noticed that he did not move the left thigh easily, and that when handled it gave him pain. The child's temperature was raised about two degrees, but the general condition was not bad. On August the 17th we saw the case together. The thigh was more tender than when the child was first seen, and the temperature had remained raised.

For the greater part of his life he had been fed on sterilised food, but there was no history of hæmorrhage from the gums, etc. In appearance the child was pale, with some evidences of rickets. There was some bronchitis.

An indefinite swelling could be felt in the region of the left hip-joint, but no crepitus, and nothing suggesting a separation of the epiphysis.

The appearance and history of the child suggested a periosteal hæmorrhage due to scurvy rickets, and we decided to put the limb at rest as far as possible, and alter the diet. The child, however, got rapidly worse, so on August the 19th he was given an anæsthetic and X-rayed. The radiograph shows two important features very clearly. (1) There was no destruction of the bones. (2) The head of the femur was at an abnormal distance from the acetabulum. This proved that the case was one of acute arthritis of the hip, and not an acute epiphysitis or osteomyelitis, nor a periosteal or epiphysial hæmorrhage. As the trouble seemed to be entirely localised to the hip Mr. Burfield decided to operate, and on August the 21st cut down on the joint. A quantity of thin pus escaped from the distended joint, but he could find no trace of bone disease. The child did remarkably well up to a certain point. The temperature became normal, and it seemed to have quite recovered, when about a month later the skin wound seemed to get re-infected. An extensive cellulitis followed, from which the child died.



The recurrence of the inflammation had not affected the hip-joint.

The case illustrates well the value of the X rays in the diagnosis of obscure joint diseases. Neither of us felt at all certain after an ordinary clinical examination as to what really was the matter, even when the child was under an anæsthetic.

No pus was collected for bacteriological investigation, but the operation was not performed under ideal conditions.

RETROSPECT OF OTOTOLOGY, 1911.

By MACLEOD YEARSLEY, F.R.C.S.,

Senior Surgeon to the Royal Ear Hospital; Consulting Aural Surgeon to the Royal School for the Deaf and Dumb, Margate; Medical Inspector of London County Council Deaf Schools, etc.

THE most important *anatomical* paper this year has been that by Mouret (translation in *J. of L.*, xxvi, p. 458) on intra-cranial dehiscences of the cavities of the ear and aqueduct of Fallopius, which should be read by all who have to do with suppurative otitis in infancy and childhood. Two papers in *pathology* which have appeared also contain items of pædiatric interest, Görke's pathology of inflammatory diseases of the labyrinth (*J. of L.*, xxvi, p. 398), and Dench's consideration of the pathological conditions of the ear resulting in profound impairment of hearing (*A.O.R.L.*, xx, p. 54).

No papers of any note upon *external ear* conditions have been published, the most important work of the year having been in the direction of otology in relation to *school medical inspection* and the *prophylaxis of deafness*. With regard to the latter much has been written upon the nasal and naso-pharyngeal conditions of childhood, and their enormous importance in the prevention of ear disease in adult life has been insisted upon—a great advance in otological therapeutics. Holmes and Emerson (*A.O.R.L.*, xx, pp. 29 and 41), have described the valuable work possible with the former's electric naso-pharyngoscope, whilst Yankauer (*A.O.R.L.*, xx, p. 418) has gone further and perfected a speculum whereby the Eustachian tube can be directly examined and treated. America has hitherto been foremost in this work, and Güntzer (*N.Y.M.R.*, ii, p. 824) has published a paper on the prophylaxis of the oro- and naso-pharynx. Similar work has been done in France by Gaudier and Lien (*E.M.N.*, xv, p. 185) and Jacques (*J.M.P.*, xxxi, p. 754) by papers on the

prophylaxis on deafness in school-children, and in England by Eustace Smith (*L.*, ii, p. 1186) on post-nasal catarrh in children and some of its consequences, and Macleod Yearsley (*Hosp.*, p. 579) on Rosenmüller's fossa and the middle ear. The grave importance of conditions in this region in the child in laying the foundations of deafness in later life was also given prominence at the Birmingham meeting of the British Medical Association by Macleod Yearsley and Hugo Frey (of Vienna) in their opening addresses to the discussion on the treatment of adhesive processes in the middle ear (*B.M.J.*, ii, p. 917).

As usual, *middle-ear suppuration and its complications* has received a large share of attention. Bowen (*L.*, ii, p. 758) points out the rôle of the "comforter" in causing otitis media. Haskin (*A.O.R.L.*, xx, p. 49) speaks of lactic acid bacilli in the treatment of otitis media suppurativa, and Page (*N.Y.M.J.*, i, p. 271) discusses the treatment of otitis media purulenta and mastoiditis in infants. Adair-Dighton (*N.Y.M.J.*, ii, p. 521) insists upon the influence of position in relation to the occurrence of mastoiditis, and Kolmer and Weston relate their experience of the treatment of one hundred cases of scarlatinal suppurative otitis media by means of vaccines. The occurrence of mastoiditis without apparent implication of the middle ear is the subject of a paper by Perkins (*A.O.R.L.*, xx, p. 423). Two papers have appeared. (*P.*, ii, pp. 239 and 867) by Pike and Burgess dealing with what the former calls permeating mastoid meningitis, in which infection is conveyed through the bony canals along the sheaths of nerves and vessels, and in which pain appears to be conspicuous by its absence. Harper (*L.*, ii, p. 430) points out the dangers of diffuse latent labyrinthitis in the radical mastoid operation, and Norman Patterson (*B.M.J.*, i, p. 988) describes a case of extensive venous infection complicating middle-ear disease and causing thoracic empyema. Allport (*A.O.R.L.*, xx, p. 400), in "Some Rambling Thoughts Concerning the Radical Mastoid Operation," condemns Heath's method as leaving "practically untouched the diseased middle ear and the diseased attic." Welty (*J. of L.*, xxvi, p. 282) describes an improved technique of the Thiersch graft following radical mastoid operations.

The aural complications of the exanthemata are discussed by Saunders (*N.Y.M.J.*, ii, p. 834), and the acute otitis of measles, diphtheria and scarlet fever by Weil (*N.O.M.S.J.*, lxiv, p. 210). An interesting case of primary sarcoma of the middle ear and mastoid in a boy aged 11 years, in which operation was followed by recovery, is related by Tobey (*B.M.S.J.*, clxv, p. 726).

In connection with the education of the deaf, an interesting correspondence by McCall, Macleod Yearsley, Rutherford and others took place in the *B.M.J.* (i, p. 1105, and ii, pp. 160, 225, and 248), whilst two papers on the medical inspection of deaf children (shortly to be published) by Kerr Love, and the classification of the deaf child (*B.J.C.D.*, viii, p. 481) by Macleod Yearsley, were read at the Conference of Teachers of the Deaf at Manchester. Three articles on the "Education of the Deaf" (*L.*, i, pp. 495, 574, and 652) by Macleod Yearsley and the important work of Kerr Love on "The Deaf Child" showed the dawn of a wider interest in the subject.

ABBREVIATIONS.

- A.O.R.L.*—‘Annals of Otology, Rhinology and Laryngology.’
B.J.C.D.—BRITISH JOURNAL OF CHILDREN’S DISEASES.
B.M.J.—‘British Medical Journal.’
B.M.S.J.—‘Boston Medical and Surgical Journal.’
E.M.N.—‘L’Echo Médical du Nord.’
Hosp.—‘The Hospital.’
J. of L.—‘Journal of Laryngology, Rhinology, and Otology.’
J.M.P.—‘Journal de Médecine de Paris.’
L.—‘Lancet.’
N.O.M.S.J.—‘New Orleans Medical and Surgical Journal.’
N.Y.M.J.—‘New York Medical Journal.’
N.Y.M.R.—‘New York Medical Record.’
P.—‘The Practitioner.’

The Royal Society of Medicine.

SECTION FOR THE STUDY OF DISEASE IN CHILDREN.

Friday, November the 24th, 1911.

Dr. G. A. SUTHERLAND, *President, in the Chair.*

Infantilism.—Dr. VINCENT DICKINSON.—Boy, aged 7 years, the youngest but one of eight children, born of apparently healthy parents; four of the children dead, the others healthy; no miscarriages. Weight 2 st. 4 lb., height 2 ft. 9 in. Forehead rather prominent, eyes large; mouth not large, tongue small and pointed; hands large, with square-topped fingers, thumb and little finger long, no curvature. Considerable deformity of bone structures, notably the clavicles, wrists, elbows, knees and ankles; marked lordosis and genu valgum; chest rachitic; abdomen large, spleen and liver not felt; no excessive sweating. Slight movements of the facial muscles and of the fingers suggesting a mild degree of athetosis. The child is not deaf, and seems to understand what is said, but he does not speak; he will

repeat a few words when told, but in a whisper only. Von Pirquet negative.

Chronic Interstitial Nephritis with Infantilism.—Dr. REGINALD MILLER.—Boy, aged $9\frac{1}{2}$ years; height, 3 ft. $1\frac{1}{2}$ in.; weight 34 lb. Full term child. Normal until the age of five months, when he had a severe attack of diarrhoea and vomiting. After this it was noticed that he took a lot of fluid and passed much urine, and that his growth became retarded. Very small for his age at three years old. Measles at four years. Six other children in the family, all healthy; no miscarriages. He has been under observation as an out-patient for two years. During this time he has grown $1\frac{1}{2}$ in. Perpetually suffers from thirst; will drink $1\frac{1}{2}$ pints of water in the night. Marked polyuria. Marked phimosis. Child is thin; skin is pale, dry and lined. He sweats only in the hottest weather. There are slight evidences of old rickets; knock-kneed. Abdomen prominent; liver, spleen, and kidneys not enlarged. The heart shows some slight hypertrophy of the left ventricle; the radial arteries are not thickened; the pulse tension does not appear abnormally high. Urine very copious; specific gravity 1002-4; thick trace of albumin, lessened, but not disappearing, after twelve hours' rest in bed. A granular cast found once.

Mentally is intelligent, but very backward; can write his own name, and begins to do sums now. Is in the infants' class at school. Wassermann test negative.

No improvement was made under a six weeks' course of thyroid extract.

Intra-cranial Tumour.—Dr. REGINALD MILLER.—Girl, aged 7 years 3 months. *History:* Had pneumonia a year ago, since when she has gradually become unsteady in her gait, and suffered from occasional sudden attacks of vomiting, associated with transient headache and giddiness.

Present state: Child has sudden attacks of headache, usually frontal; with these are attacks of typical cerebral vomiting, sudden, explosive, and sometimes brought on by change of position. Mentally the patient is happy, quick, and intelligent. Her gait is ataxic; she falls rather more to the right and backwards than in other directions. There is no ataxia of the hands; no Rombergism. Cranial nerves: Nystagmus in all directions, most marked and coarsest to right. Slight paresis of right external rectus. Vision poor; hypermetropia; no optic neuritis. Child shows "cerebellar tilt" of head, the right ear being lowered towards right shoulder and chin turned upwards and to left. Hearing good. Sensation: Sensation of movements of self are in the opposite direction from sensations of movements of external objects. Loss of sense of position in lower limbs; no areas of anæsthesia. Reflexes: Pupil, light reaction sluggish; abdominal reflexes absent (right disappearing first), arm-jerks increased, finger-flexion bilateral, ankle-clonus bilateral (right appeared first); Babinski's sign at first occasional on right, now occasional on both sides; knee-jerks increased (right increased first). Wassermann negative; von Pirquet negative.

The localisation of the tumour appears to rest between (1) a diffuse pontine glioma, with early cerebellar symptoms; (2) a right extra-cerebellar tumour; (3) a right lateral lobe cerebellar tumour.

Psoriasis and Flexion of the Terminal Phalanx of the Thumb.

—Dr. F. J. POYNTON.—Girl, aged 2 years, had suffered from rickets. Three months ago a discrete eruption began to appear, which has proved to

be psoriasis. About the same time the right thumb began to contract. There has been no pain and no other joint affected. The terminal phalanx of the right thumb is obviously flexed on the proximal and cannot be fully extended. X rays show that there is no alteration in the structure or outlines of the bones to suggest a reason for the alteration in the function of the joint. The flexor tendons of the thumb are apparently shortened, and have undergone some fibrosis.

Congenital Absence of Patellæ and Deformity of the Nails in a Mother and Three Children. Dr. A. C. D. FIRTH.—There is no history of any similar deformity on the paternal side.

The members of the family have been as follows:

Mother, aged 32 years: patellæ present on right side and rudimentary on the left, nails deformed. Girl, aged 10 years: patellæ absent, nails deformed. Is unable to fully extend the arms at the elbow and has undergone an operation for talipes. Twins (premature): died soon after birth. Sex not stated. Said to have been normal. Boy: died, aged 2 years; normal. Girl: died, aged 2 months. Patellæ absent; cleft palate. Girl, aged 4½ years: patellæ absent, nails deformed. Girl, aged 3 years: patellæ absent, nails deformed; unable to fully extend left arm at the elbow.

The deformity in no way interferes with the activity of the patients.

Hereditary Syphilitic Infant treated by Intra-venous Injection of "606."—Dr. J. L. BUNCH.—Male child, aged 8 weeks, was admitted to the hospital with an eruption which had been present for the last four or five weeks. The child presented a thin, old appearance, the skin was of a brownish-yellow tint and was covered with a maculo-papular eruption, especially well marked in the genito-crural region and on the buttocks. The papules were flattish and were present also on the hands and soles, and the eruption had a brownish tint. There were fissures at the angles of the mouth, some moist papules near the anus, and the child had snuffles.

The Wassermann reaction was positive and the *Spirochaeta pallida* was found in the skin-lesions.

On June the 21st, 1911, 0.03 grm. arsenobenzol was injected into the median basilic vein. On June the 24th the coppery eruption had greatly diminished in intensity and the ulcerated patches were much cleaner. These symptoms diminished gradually until June the 30th, when 0.04 grm. of the same drug was injected intra-muscularly into the glutei muscles.

By July the 7th all syphilitic lesions had disappeared, and the child has remained free from syphilitic symptoms until the present.

Congenital Word-Deafness and other Defects.—Dr. E. BELLINGHAM SMITH. Boy, aged 10 years, a mentally deficient child of Jewish parentage, was brought to hospital for an inability to speak and general backwardness. His appearance at first sight suggests a marked degree of mental deficiency, which is, however, more apparent than real. A right congenital torticollis causes a considerable displacement of the head to the right and a diminution in size of the face on the affected side. His walk is sidelong, with left shoulder tilted up, and his gait is staggering and ataxic; all movements which he performs are associated with a coarse tremor. There is no spasticity and the reflexes are sluggish. Sensation is normal. He exhibits a marked degree of interest in everything that goes on around him, describing them by means of gestures in a rapid and tremulous fashion. If not understood he

becomes very excited and utters a number of low guttural sounds. Speech is limited to a very indistinct enunciation of "Mumma," "Papa," and "Bert," his brother's name; these he produces by carefully watching his mother's expression as she frames the words. On a casual examination he appears deaf, but is not really so, as he can hear loud sounds, such as a bell or jingling keys, and if given a watch places it immediately to his ear and seems to appreciate its ticking. Spoken words have, however, no meaning to him whatever, and he only interprets what is meant by his accompanying gestures. Sight is said to be good for distant objects but bad for near ones. If shown figures or letters on a piece of paper he holds it close to his left eye to see them. He can copy letters, although he is considerably hampered by his associated tremor, which accompanies every movement. When writing he uses the left hand and commences with the last letter of the word and writes backwards from right to left. He can count up to twenty on his fingers and recognises the numerals when he sees them on paper.

He recognises objects in pictures and describes them by gestures, which are rapid and imperfect, like all his movements, and are frequently only intelligible to his parents. He is cleanly in his habits, not spiteful or destructive, and assists in simple domestic work at home. He is nervous and sensitive, and possesses an excellent memory.

Granuloma Annulare.—MR. HALDIN DAVIS.—Girl, aged 6 years. She suffered from a slight lateral curvature of the spine and nocturnal enuresis, but was otherwise healthy. The mother said that she was the third of six children, the remainder of whom were quite sound. The only illnesses which the patient had suffered from were chickenpox and measles; there was no history of rheumatism, tubercle, or syphilis.

Eruption, situated on the dorsum of the right hand, consists of two distinct lesions. One, the larger, extends from the metacarpo-phalangeal joints of the second, third and fourth fingers about 1 in. in a proximal direction. It is roughly circular in shape, sharply margined, and the periphery is made up of a sort of necklace of nodules closely set together round a central area, in which are only a few isolated nodules. The skin is unbroken and unaltered in colour, but the nodules can be made out, and when touched are found to be of much tougher consistency than the normal skin. Separated by a short interval and nearer the wrist is a second lesion, smaller, and made up of the same constituents, but the outline is like that formed by two intersecting circles. The centre of this patch is free. The patient was stated to have had a similar lesion last year, which disappeared.

Cerebral Aplasia with Hydrocephalus.—DR. R. SALUSBURY TREVOR and Dr. H. D. ROLLESTON showed this specimen from a male child, who died on the twenty-eighth day of life after seventeen days' illness, with symptoms suggestive of meningeal hæmorrhage or tetanus neonatorum.

The cerebral hemispheres were represented by a thin sheet of brain-tissue, fused in the middle line by union of the pia-arachnoid. The falx cerebri was absent. Over the posterior part of the left half of the sac was a sub-arachnoid collection of fluid forming a cyst, which was directly continuous with the membranous sac forming the cerebellum.

The cerebellum was represented by a cystic cavity with thin membranous walls with traces of brain-matter. The cyst projected on either side of the brain-stem in the shape of the cerebellar hemispheres, but all trace of the peduncles and the valve of Vieussens was absent. The cyst was unilocular,

and continuous with the cyst on the outside of the left half of the brain, so that the latter cyst appeared to have arisen by an escape over the free margin of the tentorium of a part of the cerebellar cyst.

The cerebrum consisted of one large cyst. There were practically no convolutions on the surface. On the floor of the cyst was a central trough running antero-posteriorly, representing the third ventricle. Above and on either side of this were two string-like bands, representing, probably, the remnants of the anterior pillars of the fornix. Across the trough ran a thread-like band representing the middle commissure. The aqueduct of Sylvius was closed. On either side of the third ventricle there was a slight projection posteriorly representing the optic thalami, and on these small cystic swellings at the site of the choroid plexuses, and beyond these the crumpled plexuses themselves. The great transverse fissure was non-existent and there was no trace of the velum interpositum, nor of the corpus callosum. The iter was non-existent. The corpora quadrigemina and geniculate bodies were represented, but the pineal gland was unrecognisable. The fourth ventricle formed the floor in the mid-line of the cerebellar cyst, and except for the upper cyst wall was roofless.

On separating the tentorium a fair quantity of blood-stained fluid was present on either side outside the cerebellar cyst. The colour of the fluid was brownish and the hæmorrhage appeared to have been of old date.

Purpura in Acute Infective Diarrhœa of Infants.—Dr. H. D. ROLLESTON and Dr. J. B. MOLONY (*vide* p. 1).

Congenital Flexion of the Proximal Interphalangeal Joints of the Fingers.—Mr. D. C. L. FITZWILLIAMS read a paper on this subject, after having shown four cases illustrating the condition. As a short and convenient name for the deformity he suggested the term "hook finger." He stated that the chief characteristics were that the first inter-phalangeal joint was flexed to a right angle, while the metacarpo-phalangeal and the terminal inter-phalangeal joints were always hyper-extended, and never flexed as was sometimes stated in books. The little finger was the one most often affected, but if the condition was present in the others as well it was less marked in those that were furthest from the little finger. The thumb was never involved. The deformity was a true congenital one and not acquired; it was most probably due to maldevelopment of the anterior ligament of the joint. The hyper-extension of the metacarpal joint showed that the palmar fascia had nothing to do with it, though shortness of this structure was the cause usually assigned in books.

In nearly all cases the condition was bilateral, and was frequently associated with laxity of the ligaments of the other joints in the body. In one case exhibited both knees could be dislocated with great ease; other congenital abnormalities were not uncommon.

If the condition was allowed to persist and more than one finger was affected, the use of the hand might be seriously interfered with. The treatment in early cases was manipulation and massage, but in old standing cases the ligament should be released from the front of the base of the middle phalanx by a fine-bladed tenotome passed into the joint from the side; in this way the tendons were not injured.

Philadelphia Pediatric Society.

JOINT MEETING WITH THE CLINICAL CONGRESS OF SURGEONS OF NORTH AMERICA, November the 14th, 1911, J. TORRANCE RUGH, M.D., President.

Pyloric Stenosis in Infancy.—Dr. CHARLES L. SCUDDER, of Boston, by invitation, read a paper on the surgical treatment of pyloric stenosis in infancy. He presented the facts about stenosis of the pylorus in infancy, the reasons why surgery offers the best treatment, and showed lantern-slides demonstrating certain facts concerning this most important condition. He described the pathology. The prognosis was fatal without treatment. The diagnosis was sometimes difficult because of mistaking pure spasm of the pylorus for a common tumour case. The treatment of the pyloric spasm alone was medical. The treatment of a pyloric tumour alone was in infancy, by operation. Posterior gastro-enterostomy was the chosen operation, as it did not interfere with metabolism. There was evidence that a pyloric tumour persisted. If this was true, the basis of the operative treatment had a good foundation. Operation should be done as soon as the diagnosis of a tumour obstruction was made.

Dr. JOHN B. DEEVER spoke in strong terms of the necessity for operation in the treatment of pyloric stenosis in infancy. He said that great numbers of these infants died on medical treatment, since the correct diagnosis was not made, the children being treated as cases of "marasmus."

Dr. EDWARD B. HODGE said that Dr. Scudder's previous paper (in 'Surgery, Gynecology and Obstetrics' for September, 1910) and this address both showed clearly the truth of two points: that this condition could be successfully treated surgically, and that these patients grew up into healthy children. But these cases all had organic tumour. Dr. Hodge thought there was danger of operating upon patients who had no tumour, cases which could be treated successfully medically. The surgeon should be called in early, that both physician and surgeon might study the case together. The operation was relatively safe, the mortality now being under 10 per cent.

Dr. HARRY LOWENBURG referred to a patient of his, reported recently, upon whom operation had been successful at the age of six weeks. He had observed five cases of pyloric stenosis. He considered absolute constipation the most important indication for operation—more important than palpable tumour or peristaltic waves. The motions in cases which required operation consisted of bile stained mucus only.

Dr. ROLAND MILL, of St. Louis, had seen many such cases treated medically; but recently he had had a baby of five weeks operated upon successfully.

Dr. SCUDDER, in closing, described his technique. Infants must be kept thoroughly warm during operation. A skilled anaesthetist was necessary. If the baby got blue, a little oxygen would overcome the difficulty. The only disinfection used was 70 per cent. alcohol for bathing the abdomen before operation. The incision should be low and to the left of the umbilicus, and must be long. He took out of the abdomen only the part to be operated on. He selected the jejunum, close to the ligament of Treitz,

for the anastomosis. The incision in the stomach and intestines should be about an inch long. He used linen and zero chromic gut for sutures. The abdominal wound was closed with interrupted sutures, layer by layer. After operation whey was given first, two drachms every hour, by medicine dropper increased gradually if there was no vomiting. It seemed unfair to the surgeon for the physician to have starved the infant before handing it over to the surgeon for operation.

Some Differences between the Surgery of Children and Adults.—

Dr. CHARLES N. DOWD, of New York, by invitation, read this paper. Dr. Dowd spoke of three topics in which the surgery of children differed from that of adults, one in the neck, "Inflammation of Tubercular Lymph-Nodes," one in the chest, "Suppurative Pleurisy or Empyema," and one in the abdomen, "Tubercular Peritonitis." He spoke of 465 operated neck cases. Fifteen were in young children who showed more tuberculosis in other parts of the body than the clear children; eradication of the disease was more difficult. None died after operation, but two died later, one of general tuberculosis, the other of tubercular meningitis. Twelve had been traced and were still in good condition. Between the ages of two and seventeen years the clinical picture was fairly definite. Lymph-nodes in the upper part of the neck broke down before the lower ones were involved. In this group were 374 patients. The nodes were thoroughly removed, with an operative mortality of $\frac{1}{4}$ per cent. Patients were usually out of bed in three days, and out of the hospital within ten days. About 75 per cent. were free from recurrence, and about 90 per cent. ultimately cured. The scar resulting was insignificant. In adults the inflammation was apt to extend to the lower lymph-nodes of the neck before a cold abscess formed above. The tubercular inflammation was more extensive and the operation more difficult, but still gave excellent results.

Dr. Dowd had observed 204 cases of empyema in children to forty cases in adults. In children the empyema was usually but a part of a general pneumococcic infection; 51 per cent. healed promptly after opening the chest and resecting a small piece of rib, 19 per cent. healed more slowly, while 30 per cent. died with evidence of pneumonia, peritonitis, pericarditis or other general infection; 79 per cent. of the bacteriological examinations indicated pneumococci as the infecting agent. The patients in whom lung contraction persisted usually did well with thoracoplasty and decortication. In adults only 32 per cent. showed pneumococcic infection. Here the results of thoracoplasty and decortication were less favourable.

Dr. Dowd had observed forty-six children and thirty adults with tubercular peritonitis. Fluid was present in the children in marked degree only seven times, and in only four instances could the appendix be removed. Several of these patients showed marked improvement after the operation. Of the adults 40 per cent. had excessive amounts of fluid; 50 per cent. had the lesion so localised that either a portion of the intestine or the uterine appendages were removed.

Dr. HENRY R. WHARTON was surprised that Dr. Dowd had not seen more cases of tubercular lymph-nodes in the neck of children under one year of age. He agreed with Dr. Dowd that their occurrence was more frequent after that age. Dr. Wharton believed that if operation for empyema was done early, recovery resulted. In infants he usually employed intercostal drainage; in children he removed a portion of a rib. In tubercular peritonitis he operated when abdominal effusion was present, without

breaking adhesions, since free manipulation was apt to be followed by the development of fæcal fistula.

Dr. JOHN N. JEPSON advised calling all cases of cervical adenitis tubercular, since that statement decided parents to permit operation, which nowadays consisted of total extirpation of the glands. If the disease was eradicated a permanent cure was reasonably sure. He could not recall a case of empyema in a child which did not follow pneumonia. Dr. Jepson referred to a child now under his care with tubercular peritonitis, complicated by hepatic cirrhosis, who had done well since the operation.

Dr. DOWD, in closing, spoke of the after-treatment of these cases. The empyema patients were not benefited by any suction apparatus more than when simple drainage into the dressing was secured. In the neck drainage was also important. Good hygienic surroundings were of value for all of these patients. The good results in the neck cases lead one to believe that the inflammation must have been localised to a comparatively small area of the neck.

Stereo-arthrolysis.—Dr. R. TUNSTALL TAYLOR, of Baltimore, by invitation, read a preliminary report and experimental study in arthroplasty. After reviewing the literature upon the treatment of ankylosis, he discussed the embryology of the articulations and the effect of muscular activity upon joints. He then enumerated the essentials in forming a new joint and described the various waxes, mixtures of which he used in his experiments. After describing investigations in the formation of new joints in ten rabbits, Dr. Taylor gave in detail the histories of four patients for whom he made new joints with mobility in place of ankylosed joints. This work was done in the past six months, in the James Lawrence Kernan Hospital for Crippled Children in Baltimore.

Dr. M. A. WILSON commented upon the fact that the muscular atrophy from disuse in long-standing cases of ankylosis was the most serious factor. So far he had used chronicised pig's bladder, as recommended by W. S. Baer, but he was now going to try wax. Permanent success depended on the selection of patients with fibrous ankylosis; the avoidance of operation in joints that were seriously deformed or of long standing; the removal of enough joint to secure great freedom of motion; early institution of passive motion; early establishment of voluntary muscular control; the avoidance of fixation appliances that interfered with normal function.

Dr. G. G. DAVIS said that this subject was as interesting to the orthopædic surgeon as cancer was to the general surgeon. Attempts to produce movable joints by introducing foreign bodies had been failures, as had also the removal of a large amount of tissue from the joint. Yet ankylosis of the elbow treated by resection had given some pretty good joints after all. In the knee, of all ankylosed joints, it was most difficult to get a good result. If the wax did not irritate, the problem was almost solved.

Dr. TAYLOR, in closing, said that this method seemed more helpful in cases of osseous ankylosis than in the fibrous types of rheumatoid and gonorrheal origin. It was best not to move the joints for three weeks after operation, although traction should be used by the end of the first week. The silver skin suture should be left in three or four weeks, as the capsule had been dissected away.

Société de Pédiatrie, Paris.

October the 20th, 1911. (Bulletin No. 7.)

Bruit in a Pulmonary Cavity.—MM. VARIOT and P. PETIT described the case of a boy, aged 7 years, who had on the left side of the thorax a cavity in which a splashing sound synchronous with the pulse was heard. There was no fever nor constitutional disturbance and Koch's bacillus was not found. The cavity was probably due to a purulent pleurisy with extensive sclerosis of the parenchyma. Radiography showed an almost complete opacity of the left lung.

Arterial Transposition; Congenital Cyanosis without Murmur.—MM. VARIOT and MORANCÉ showed the heart of a boy, aged 3 years, in which the aorta arose from the right ventricle and the pulmonary artery from the left, the large veins being normally placed. There was cyanosis increased by the efforts of defæcation, but no bruit. The arterial blood seemed to pass into the general circulation by the interventricular perforation, the foramen ovale and the ductus arteriosus; the venous blood by the bronchial arteries, which were remarkably large.

(?) **Amyatonia Congenita.**—MM. GUINON and GAUDUCHEAU described the case of a boy a few months old, the subject of partial muscular atony without paralysis, with occasional hypertonus of certain muscular groups, exaggerated extension of the head, and subluxation of the inferior maxilla. On examining the child in bed he appeared at first sight to be in a condition of extreme opisthotonos. The head was hyper-extended, the occiput lying on the interscapular region of the spine. The limbs were flexed except at the extremity. The child remained motionless for hours together, sometimes crying without being able to reduce the luxation of the inferior maxilla. The immobility was not, however, continuous. As soon as one tried to move the child a certain rigidity first of all became apparent; the various segments of the body were as though fixed in these positions, but the rigidity soon gave place to an abnormal flaccidity allowing very free passive movements. The child moved its limbs spontaneously to a fair extent in spite of evident muscular weakness. These movements seemed feebler and more limited at the root of the limbs than at their extremity, and this was specially noticeable with regard to the arms. The movements were in a marked degree *syngkinetic*: if on pinching a finger a flexion of the arm was provoked, this movement was also taken up by the other limb. The absence of Trousseau's and Chvostek's signs and of galvanic hyper-excitability of the nerves was against the hypothesis of an abnormal form of tetany. The excessive flexion of the head was exaggerated when the child was raised by a hand applied to the lumbar region. But if the child was turned over on its stomach the head did not immediately take up a position of anterior flexion, and the extensor muscles could be seen in parallel columns below the nuchal region. Respiratory movements were feeble; respiration seemed more diaphragmatic than costal, and the vesicular murmur was feeble. The enormous opening of the mouth was very striking, and could only be explained by a subluxation of the lower jaw with extreme mobility. Suction was impossible, and milk had to be poured down the

child's throat. The eyeballs were not completely covered during sleep, and there was a certain degree of bilateral ptosis. Nystagmus was present.

M. MARFAN described two somewhat similar cases which he classed under the name of *Little's disease of tetaniform type*.

Woodcuts of this interesting case are given in the 'Bulletin.'

Prolonged Cerebro-spinal Meningitis with Cachexia.—M. ROBERT DEBRÉ showed a boy, aged 8 years, who had presented all the symptoms of acute cerebro-spinal meningitis with clear cerebro-spinal fluid. Instead of recovering under serum treatment he developed dulness of intellect, disturbances of the sphincters, diffuse amyotrophy, paresis with rigidity, and a condition of profound cachexia. He became subject to acute attacks in which all the symptoms were exaggerated; the retraction of the neck resembled that of acute tetanus; the headache was so intense that he shrieked day and night, and there was also intractable vomiting. Between the attacks there was cerebral torpor. Lumbar puncture and intra-spinal injection of serum gave no relief. After five months optic atrophy was noted. A month later M. Broca removed a large piece of the right parietal bone. The immediate results of the operation were good: the cerebral torpor disappeared two days after the operation, there was no more headache, and the vomiting ceased. The rigidity gradually diminished, and at the present time the child had no symptoms but blindness.

Subacute Intussusception in a Child of 5½ months.—M.M. GUINON and FAUGUEZ reported this case, the points of interest being a long evolution divided into three distinct periods: A phase of intolerance characterised by a serious disturbance of the general condition, continuous pain and partial refusal of food, the passage of blood-stained mucus without faecal matter lasting six or seven days. A second phase of improvement during which the pain diminished and feeding became possible, the child taking 500 grm. of liquid, of which 250 to 300 grm. consisted of humanised milk. The child was cheerful and able to sleep, and the motions became distinctly faecal and almost free from mucus. A third phase in which the condition became rapidly worse, and characterised by thrush, vomiting, and refusal of food. Laparotomy was performed about five weeks after the onset, but the case ended fatally.

VINCENT DICKINSON.

Abstracts from Current Literature.

Medicine.

Diphtheria in the Metropolitan Asylums Board hospitals ('*M.A.B. Rep.*' 1910).—3634 cases were admitted during 1910 as compared with 4393 during 1909 (*vide* BRITISH JOURNAL OF CHILDREN'S DISEASES, 1910, VII, p. 409). Exclusive of purely bacteriological cases the percentage mortality was 7.9, the lowest on record. The mortality at the various hospitals ranged from 5.2 to 9.5 per cent. Among 668 laryngeal cases there were 86 deaths, a mortality of 12.9 per cent. On 231 tracheotomy, on 45 intubation, and on 11 both operations were performed, among whom there were 50, 6 and 5 deaths respectively. The percentage errors in cases admitted was

14-1. Among the 599 wrongly certified as diphtheria were 401 of tonsillitis, 44 of laryngitis, 42 of Vincent's angina, 21 of pneumonia, and 11 had no obvious disease. Of complications, paralysis occurred in 16-18 per cent., albuminuria in 29-3 per cent., and otitis in 5-6 per cent. Serum rashes were noted in 37-4 per cent., joint pains in 4-6 per cent., and abscesses at the injection site in 0-6 per cent. The report contains tables showing the yearly incidence rate per cent. of complications amongst cases of diphtheria during the last nine years, and a summary of antitoxin treatment including tracheotomy and intubation statistics during the same period.

J. D. ROLLESTON.

Nasal diphtheria in children (*Arch. de méd. des Enf.*, 1911, xiv, p. 833.)—Mme. de Biehler and B. Korybut-Daskiewicz review the literature and record nine cases of exclusively nasal diphtheria. Eight occurred in infants, aged from 4 to 11 months, and one in a child, aged 4 years. Some of the cases showed slight pyrexia, but in many the temperature was not raised. No palsies occurred. Rapid recovery followed injection of from 1000-2000 units of antitoxin.

J. D. ROLLESTON.

Wound diphtheria (*Boston Med. and Surg. Journ.*, 1911, II, p. 329).—F. A. Thompson, jun., and M. R. MacAusland.—A boy, aged 10 years, was admitted to hospital with compound fracture of the right patella. After surgical treatment the wound healed by first intention, but in the latter half of the third week pus appeared at the inner end of the skin incision, and the whole area became covered with a greyish white membrane. Diphtheria bacilli were found in the cultures, and in the course of a fortnight 40,500 units were injected. The actual diphtheritic process lasted three weeks, but it was not until forty-one days from the time that diphtheria bacilli were first found that the cultures became negative. The wound finally healed, after the upper and outer fourth of the patella had necrosed.

J. D. ROLLESTON.

Diphtheria of stomach (*Bull. et Mém. Soc. Anat. de Paris*, 1911, 6 sér., xiii, p. 326).—P. Harvier and R. Rolland.—At the necropsy of a child, aged 4 years, who had died of hæmorrhagic diphtheria without any œsophageal or gastric symptoms during life, five small radiating patches of membrane were found at the cardiac orifice ranging from 5 to 8 mm. in length and from 1 to 2 mm. in width. A pure culture of long diphtheria bacilli was obtained from one of them. The histological structure was typical of diphtheritic membrane (*cf.* BRITISH JOURNAL OF CHILDREN'S DISEASES, 1910, vii, p. 409).

J. D. ROLLESTON.

Gangrene of leg following diphtheria (*Lancet*, 1911, I, p. 94).—A. S. Ransome and E. M. Corner.—A boy, aged 6 years, in the second week of diphtheria treated with antitoxin, developed signs of cardiac failure. On the 17th day he had very acute and sudden cramp in the right leg, and two days later discoloured patches appeared on the foot and leg. The urine was scanty and albuminous. Palatal palsy occurred on the 37th day. On the 48th day a line of demarcation appeared at the junction of the lower and middle third of the leg. Amputation was performed just below the knee on the 46th day after the embolism and on the 61st day of illness. The lumen of the popliteal artery was free of clot. The embolus was therefore higher up, possibly at the origin of the superficial femoral. Recovery took

place. **H. Kramer** (*Brit. Med. Journ.*, 1911, II, p. 505) records another case in a girl, aged 11 years, who fourteen days after the onset of severe faucial diphtheria treated with antitoxin developed gangrene of the leg. A few days after the gangrene had reached the tubercle of the tibia amputation was performed. Recovery was delayed by the occurrence of measles nine days after the operation. There was no diphtheritic paralysis.

J. D. ROLLESTON.

Sudden death after diphtheria (*Austral. Med. Gaz.*, 1911, XXX, p. 451).—**S. Sheldon** describes a case of a girl, aged 14 years, in which death suddenly occurred from the plugging of the air passage by a slough about two inches long in the trachea. The child had been convalescent from diphtheria for six weeks.

F. R. B. ATKINSON.

Serum reaction (*The Canad. Pract. and Rev.*, 1911, XXXVI, p. 267).—**W. Goldie** says that serious serum reaction does not occur in children. There was no death or any serious trouble amongst 9000 children who were given 500 units of anti-diphtheritic serum every two weeks in hospital, and later 1000 units every three weeks for two years. Reactions do occur, but they appear to depend rather upon the individual than upon the serum. Most of the reactions follow the first injection, and in that patient subsequent doses will always produce a reaction. The most severe reactions appeared amongst the nurses and house staff. The chief phenomena were, local reaction at the site of injection with swelling, induration, pain, and an urticarial rash. The rash may be general and is usually urticarial in character; it may develop within a few minutes to a fortnight after the injection; it lasts one to two days. Joint pains are uncommon in children. Occasionally a severe reaction occurs; within a few minutes after the injection the child becomes restless, pale, and exhausted, there is great local reaction, swelling and induration, the pulse and breathing are hurried and cyanosis appears; finally death seems imminent. When the pulse improves a giant urticaria appears over the body and in the mouth and throat with post-sternal distress and dyspnoea like asthma indicating the same condition of the bronchial mucous membranes. The first stage reaches its height in ten minutes, but the urticaria, unless relieved by morphine, may last one or two days.

J. PORTER PARKINSON.

Serum eruptions and calcium chloride (*Thèses de Paris*, 1910-11, No. 446).—**A. Gouvalska**.—Since 1905 Netter has given calcium chloride to his diphtheria patients at the Hôpital Trousseau in Paris with the object of preventing serum eruptions. The percentage of serum rashes in 677 cases who received prophylactic doses was 3.6 as compared with 16.4 among 724 cases not so treated (*cf. BRITISH JOURNAL OF CHILDREN'S DISEASES*, 1907, IV, p. 462, and 1911, VIII, p. 134).

J. D. ROLLESTON.

The untoward effect of diphtheria antitoxin (*Med. Record*, 1911, I, p. 15).—**R. Wallace** suggests that suprarenal insufficiency is the cause of the sudden death which may occur after the administration of serum in sensitised persons or in those subject to bronchial asthma or other forms of respiratory disorders. He recommends for such cases the hypodermic injection of adrenalin both as a prophylactic measure prior to the administration of serum and as a curative treatment for acute forms of the serum disease.

J. D. ROLLESTON.

Carriers in relation to the spread of diphtheria (*Med. Record*, 1911, i, p. 1043).—**E. C. Hill** says that the diphtheria bacillus has no extra-corporeal existence except in milk, hence house disinfection is useless, and since this practice was dropped in Providence, R. I., there has been no increase in the ratio of recurrences to infected families. The present epidemic consisted of sixteen cases occurring in the officers' quarters. In addition to these clinical cases thirteen carriers were found in those living in the same dwellings and nine among the surrounding tradespeople. The first case occurred in a butcher, and after a long illness ended fatally. The second case was thought to have developed the disease two days later, but no notice was taken till nearly a month, when symptoms of toxic neuritis of the pneumogastric developed, followed by a temporary paralysis of the left arm and forearm: thirty-eight thousand units of antitoxin were given and digitalis and strophanthus were used to combat the cardiac weakness. At the time of writing there was a partial recovery. Two other serious cases are recorded. The first case was the only one fatal. All inmates were quarantined, and prophylactic doses of 1000 units were given to all irrespective of age. No baneful results are recorded. Cultures were made from 287 inanimate objects, and the germs of the disease were found in five, three of these being from the gauze protecting telephone mouthpieces, one from the hair of a doll, and the last from the feet of a "teddy bear." The authors conclude by attributing this and other epidemics to human carriers and not to fomites.

CHRISTOPHER ROLLESTON.

Treatment of diphtheria bacillus carriers (*Arch. Internat. Med.*, 1911, vii, p. 16).—**H. Page** agrees with H. W. Fisher (*Journ. Amer. Med. Assoc.*, 1909, LIII, p. 439) that four successive negative cultures are imperative before a patient is released from quarantine. Schiotz, of Copenhagen, observing that patients with staphylococcus sore throats admitted in error to diphtheria wards did not contract diphtheria, and that intercurrent attacks of staphylococcus sore throat terminated Klebs-Loeffler bacillus findings in diphtheria convalescents, inoculated six diphtheria bacillus carriers with staphylococci with success in each case. Page now records a case in which after ineffectual use of ordinary throat sprays and repeated injections of antitoxin, two-hourly spraying of the throat with bouillon cultures of *Staphylococcus pyogenes aureus* rendered the throat free of bacilli in a few days. **S. R. Catlin, L. O. Scott and D. W. Day** (*Journ. Amer. Med. Assoc.*, 1911, LVII, p. 1452) record eight further successful cases. In none of these fifteen cases did any harmful results occur. The bacilli disappeared in from forty-eight to seventy-two hours.

J. D. ROLLESTON.

Scarlet fever in the Metropolitan Asylums Board hospitals (*M.A.B. Rep.*, 1910).—8782 cases were admitted in 1910 as compared with 15,384 in 1909 (*vide BRITISH JOURNAL OF CHILDREN'S DISEASES*, 1910, vii, p. 409). The mortality was 2.4 per cent. The percentage error of diagnosis was 9.5. Among the 918 cases wrongly certified were 224 of German measles, 131 of tonsillitis, 226 of erythema; 115 had no obvious disease or were not diagnosed. The commonest complications were otitis (12.64 per cent.), albuminuria (8.53 per cent.), secondary adenitis (7.08 per cent.), nephritis (5.14 per cent.), and rheumatism (3.87 per cent.); 261, or 2.74, had relapses. There were 165 cases of post-scarlatinal diphtheria with one death, a mortality 0.61 per cent. Nine of the post-scarlatinal cases were laryngeal, but all recovered. The report contains instructive tables showing the

yearly incidence of complications during the last nine years, the number of cases in which two or more separate infectious diseases were co-existent at the time of admission, and the incidence of post-scarlatinal diphtheria during the same period.

J. D. ROLLESTON.

Recurrence of scarlet fever (*New York Med. Journ.*, 1911, II, p. 771, and *Med. Record*, 1911, II, p. 249).—**J. P. Crozer Griffith** at a meeting of the American Pediatric Society said that recurrence of the typical forms of scarlet fever was very rare, though cases were reported by many writers. His own case was in a boy, aged 2 years, the son of a physician. A week after the first attack, in which the tongue, throat and rash were typical, the child developed measles, the desquamation of which was concealed or replaced by that of scarlet fever. Thirteen months later he had a second attack of scarlet fever followed by typical desquamation and nephritis. In the subsequent discussion, **Emmett Holt** mentioned a case in which the first attack occurred at seven years, and the second at twenty-four. Both were severe and typical. **C. G. Kerley** reported two cases, one in a girl, the daughter of a physician, and the other in a boy who had desquamated freely after the first attack. The second attack was undoubtedly genuine. **A. Jacobi** in his long life had seen only two cases, but they were both definite and he had seen both attacks. There were fever, eruption and desquamation, and in one nephritis.

J. D. ROLLESTON.

Myocarditis and sudden death in scarlet fever (*Presse Méd.*, 1911, XIX, p. 17).—**E. Weill** and **G. Mouriquand** record a case of malignant scarlet fever in a youth, aged 19 years, in whom cardiac disturbance had been pronounced from the onset. A syncopal attack occurred on admission to hospital. The next day embryocardia and arrhythmia appeared, but later the pulse suddenly changed from being rapid and filiform to a condition of normal regularity. On the sixth day of disease sudden and fatal syncope occurred. Necropsy: Recent pericarditis at base of heart; numerous hæmorrhages along branches of coronary artery, myocardium soft and of a dead leaf colour, having histologically leucocytic infiltration of its fibres. Suprarenals and thyroid healthy. The writers, without denying the existence of cases in which sudden death may be due to changes in the suprarenals (*v. BRITISH JOURNAL OF CHILDREN'S DISEASES*, 1910, VII, p. 410), insist on the importance of a careful examination of the myocardium in all cases of sudden death.

J. D. ROLLESTON.

Peripheral neuritis following scarlet fever (*Bull. et Mém. Soc. méd. Hôp. de Paris*, 1911, XXXII, p. 332).—**Chavigny** records a case in a soldier convalescent from severe scarlet fever. Cultures of the throat showed an absence of diphtheria bacilli and he had no albuminuria nor rheumatoid pains in the joints. On the fifteenth day of convalescence diffuse pain occurred in the right lower limb and persisted for some time, but was never very severe. On leaving hospital he had some difficulty in walking, and the muscles of his right hip and thigh were much wasted. Electrical reactions showed a diminution of contractility in all the muscles, but especially in the quadriceps, in which no response was given to faradism. Treatment was of no avail.

J. D. ROLLESTON.

Abnormal measles (*Arch. de Méd. des Enf.*, 1911, XIV, p. 445).—**G. Baldini** records five cases seen in a recent epidemic in Paris: (1)

Hyperpyrexia in a boy, aged 11 years, without apparent complication. During the height of the eruption the temperature reached 106.2° F. After a dose of cryogenine it fell to subnormal the next day, and the disease pursued a normal course. (2) Fatal case of hyperpyrexia (temperature 106.8° F.) without obvious complications in a male infant, aged 18 months. (3) Boy, aged 7 years. Development of measles in the course of lobar pneumonia. Laryngitis and bilateral cervical adenitis five days after the appearance of the eruption. Recovery. (4) Sister of (3), aged $5\frac{1}{2}$ years. Epistaxis and generalised purpuric eruption. Recovery. (5) Fatal case of hæmorrhagic measles in a female infant, aged 25 months, characterised by marked prostration, high fever, ecchymotic eruption and intestinal hæmorrhage. There was albuminuria, but no obvious hæmaturia. Death was preceded by vomiting and green stools.

J. D. ROLLESTON.

Period of infectivity of blood in measles (*Journ. Amer. Med. Assoc.*, 1911, II, p. 113).—J. F. Anderson and J. Goldberger.—The results obtained from the inoculation of six monkeys with human blood drawn from cases of measles point to the period of infectivity beginning at least just before, and continuing for about twenty-four hours after, the first appearance of the exanthem. At the end of about twenty-four hours from the first appearance of the eruption the infectivity of the blood for the *rhesus* monkey already appears greatly reduced and becomes progressively less subsequently.

J. D. ROLLESTON.

Subclavian thrombosis in measles (*Glasgow Med. Journ.*, 1911, I, p. 191).—A. J. Couper.—A male child, aged 18 months, was admitted to hospital with an ordinary attack of measles. The temperature became normal on the twelfth day, but on the sixteenth rose to 102° F. On the following day the back of the right hand became swollen and cedematous; and in the next few days the whole of the right arm and thorax were involved. The limb became cold and mottled. Gangrene developed and death took place on the twenty-first day. Post mortem, a firm adherent clot was found in the subclavian vein. Attempts to grow cultures from the clot failed. The heart and pericardium were normal. The brain was not examined. No similar case could be found in the literature.

J. D. ROLLESTON.

Measles complicated by subcutaneous emphysema (*Gazz. degli Osp.*, 1911, xxxii, p. 679).—M. Gioseffi.—A boy, aged 2 years, fell ill with measles complicated by broncho-pneumonia. Six days after the appearance of the eruption subcutaneous emphysema developed, first on the neck and cheeks, and then spreading on the trunk and limbs. Death took place on the third day of the emphysema. There was no constant cough as in some of the cases recorded (*cf. BRITISH JOURNAL OF CHILDREN'S DISEASES*, 1910, VII, p. 411).

J. D. ROLLESTON.

Generalised cutaneous emphysema in children (*Riv. di Clin. Ped.*, 1910, VIII, p. 748).—M. Gioseffi records two fatal cases, one in a boy, aged $5\frac{1}{2}$ years, in the eruptive period of measles complicated by broncho-pneumonia, and the other in a girl, aged 7 years, who had been intubated for laryngeal diphtheria. In both cases he attributes the emphysema to laceration of the pulmonary alveoli caused by increased endo-alveolar pressure resulting from persistent and violent coughing. Including his own cases Gioseffi has collected

fourteen examples of cutaneous emphysema following measles with seven deaths, and eight following intubation for diphtheria. J. D. ROLLESTON.

Varicella in an adult ('*Progrès méd.*,' 1911, 3 s. xxvii, p. 440).—**M. and Mme. Savini** record a case in a previously healthy woman, aged 38 years. The prodromal period, which is usually very short and poor in symptoms, in this case lasted ten days, and was characterised by intestinal colic, diarrhoea and syncopal attacks. These symptoms ceased as soon as the eruption appeared. Of her two children, one who had already had varicella escaped, while the other had an ordinary attack fifteen days after the appearance of the mother's eruption. The patient's sister, who had previously had varicella, presented similar prodromes (cf. *BRITISH JOURNAL OF CHILDREN'S DISEASES*, 1910, vii, p. 412). J. D. ROLLESTON.

Varicella in an adult ('*Med. Klinik*,' 1911, vii, p. 883).—**P. Misch** records a case in a young woman in whom the diagnosis was confirmed by successful vaccination after recovery from the attack of varicella. J. D. ROLLESTON.

Exanthemata after vaccination in children ('*Arch. de Méd. des Enf.*,' 1911, xiv, p. 264).—**Mme. de Biehler** finds that eruptions after vaccination are not frequent. Out of 1070 cases of vaccination there were only thirty-six exanthemata, *i.e.* 3·3 per cent. The eruptions most commonly met with were erythema multiforme, scarlatiniforme, morbilliforme, and urticaria. The symptoms are the same as those met with in the serum disease: between the eighth and fourteenth days a slight elevation of temperature and enlargement of the glands, which become painful, oedema, chiefly of the face, and albuminuria, articular pains, and leukopenia. The writer finds that the cause of the exanthemata after vaccination is the same as after the injection of serum, *viz.* the union of specific antibodies with the vaccine or the serum of the animal. F. R. B. ATKINSON.

Vaccination in pregnant women and new-born children ('*Thèses de Paris*,' 1910-11, No. 184).—**V. Mas**.—In a large proportion of children whose mothers were successfully vaccinated during pregnancy, vaccination performed shortly after birth was unsuccessful. The number of failures was highest in those children whose mothers had been vaccinated before the eighth month of pregnancy. J. D. ROLLESTON.

The dangers of whooping-cough ('*Journ. de Méd. de Bordeaux*,' 1911, xli, p. 389).—**R. Saint-Phillippe**.—The lay public consider whooping-cough a trifling complaint, and frequently do not call in a doctor; often also owing to the whoop being absent it passes unperceived: in 600 cases more than 100 had no whoop. It is useful to know that if it is desired to produce a cough during the doctor's visit it can be done by gently scratching the exterior of the trachea with the finger. If there be any doubt the sputum can be examined for the specific organism described in 1906 by Bordet and Gengou, or the test of the deviation of the complement may be employed. The diagnosis is of the greatest importance, for directly or indirectly whooping-cough has a large number of victims, and the bad cases are those which have not been recognised early enough. J. PORTER PARKINSON.

Whooping-cough (*'La Semana Medica,'* 1910, xvii, p. 1617).—**Escobar**, in a very full account of this disease, recommends menthol as a specific on the basis of some clinical observations. He makes a solution of 10 cgm. in 130 grm. of alcohol, syrup and water. Of this children under one are given a teaspoonful during 24 hours (in small doses), from 1 to 2 years three teaspoonfuls, and 2 to 5 years, three to five teaspoonfuls. With menthol thus given the paroxysms soon cease and the cough subsides.

M. D. EDER.

A case of tetanus (*'Ind. Med. Gaz.,'* 1911, xlvi, p. 196).—**D. G. Asana** reports a case of tetanus in a girl, aged 12 years, following on an abscess of the great toe of the right foot. The treatment adopted, and which ended in complete recovery, was as follows: (1) Antiseptic cleaning of the foot; (2) removal of the toe under chloroform; (3) intra-spinal injection, after lumbar puncture of 2.5 c.c. sterilised solution of magnesium sulphate; (4) nursing and milk diet. The author does not attribute the cure to the spinal injection but to the removal of the toe.

F. R. B. ATKINSON.

Case of tetanus treated with intra-spinal injections of magnesium sulphate (*'Austral. Med. Journ.,'* 1911, xvi, p. 265).—**M. C. Gardner** treated a child aged 8 years successfully, suffering from tetanus, in the following manner: Three c.cm. of sterilised 25 per cent. solution of magnesium sulphate were injected intra-spinously every twenty-four hours, 5 for four injections, then 4 c.cm. for the next eleven, and 3 c.cm. again for the last two, making seventeen injections in all. Rectal salines were given four hourly from the third to the fifteenth day, brandy and glucose being added. The patient also received 160 c.cm. of anti-tetanic serum subcutaneously during the first five days: it was then discontinued and again given on the twenty-first and twenty-second days. On the fifteenth day ten minims of a 2 per cent. solution of phenol were injected three-hourly, the dose being increased to 20 minims by the fourth day. This was continued for five days. The author did not find any benefit accrue from any of the remedies employed save the magnesium sulphate.

F. R. B. ATKINSON.

Is anti-tetanic serum a factor in the cure of tetanus? (*'New York Med. Journ.,'* 1911, i, p. 830).—**J. C. Kennedy** narrates a case of tetanus in a boy, aged 8 years, after a compound fracture of the frontal bone. The tetanic symptoms began nine days after the operation, and lasted sixteen days, during which time 19,500 units of antitoxin serum and 1714 grains of chloral and bromide of sodium were administered. The patient was dismissed cured six weeks after the accident.

F. R. B. ATKINSON.

Typhoid fever in children (*'Jahrb. f. Kinderheilk.,'* 1911, lxxiii, p. 475).—**H. Vogt** records his observations on an epidemic in an orphanage near Strassburg. No deaths occurred, and no cases of hæmorrhage or perforation were observed. [The number of children affected is not stated.—**J. D. R.**]. The course of the disease as age advanced began to resemble that of the adult. Vogt's experience does not confirm the statement frequently made that typhoid in older children runs a relatively severe course. A more liberal diet than usual was allowed, most of the children being given mince biscuit and bread from the onset, and a large number potato broth and finely divided vegetables as well. The loss of weight among the children was consequently only moderate, and no cases of severe cachexia occurred.

J. D. ROLLESTON.

Typhoid fever in a suckling (*Arch. de Méd. et Chir. inf.*, 1911, xv, p. 533).—**C. Achard** and **Flandin** narrate a case of typhoid fever in a girl, aged 11 months, who recovered. The case did not conform at all, as is frequently the case in children, to the clinical type of adults, and the authors rested their diagnosis on the sero-diagnosis, which was markedly positive.

F. R. B. ATKINSON.

A case of typhoid fever in a suckling with a rare complication (*Monatsschr. f. Kinderheilk.*, 1911, ix, p. 653).—**F. Kaspar** describes a case of a babe, aged 10 weeks, admitted into hospital with a swollen knee. Three weeks before admittance he had suffered from catarrh of the bowel. The swelling was manifestly an abscess, and the pus removed showed pure cultures of the typhoid bacillus. The bacilli were found in the urine. The author considers the germ was transmitted from unboiled water used to thin the milk the child was taking and set up a general septic typhoid disease. A month after the abscess had healed pleuro-pneumonia set in and carried him off. Post-mortem examination revealed numerous abscesses of the lung and pleura.

F. R. B. ATKINSON.

Abortive typhoid fever in children (*Thèses de Paris*, 1911-12, No. 43).—**C. Collignon** says that abortive typhoid fever is remarkably frequent in children. It is characterised by its sudden onset, short duration, and rapid disappearance of symptoms. There is always, however, the possibility of a grave relapse. The thesis contains the histories of twelve cases, seven of which are original, in children up to 14 years. The duration of the disease was from seven to twenty days. In the great majority a positive Widal's test was obtained. In two cases intestinal hæmorrhage occurred and in one a mild relapse. All recovered.

J. D. ROLLESTON.

Typhoid fever infection involving only the gall-bladder (*Arch. of Pediat.*, 1911, xxviii, p. 217).—**W. G. Elmer**.—A girl, aged 16 years, became feverish eighteen days after drinking some typhoid-infected milk. The gall-bladder became distended and tender, but otherwise there were no abdominal symptoms. The pyrexia ran an irregular course with marked daily remissions and lasted about twelve days. Three typical rose-spots appeared, and Widal's test was positive. Complete relief occurred when the gall-bladder began draining itself, and the temperature became normal thirty-six hours later and remained so.

J. D. ROLLESTON.

Pericarditis in typhoid fever (*Bull. et Mém. de la Soc. Méd. des Hôp. de Paris*, 1911, xxxi, p. 751).—**Triboulet** and **Harvier** record a case in a boy, aged 11½ years, who died with multiple intestinal perforations after very severe typhoid fever. The diagnosis of pericarditis was not made during life, but at the necropsy the pericardium was found distended by a clear fluid, centrifugalisation of which showed endothelial cells only. Cultures of the fluid yielded typhoid bacilli. The writers could not find the report of any other case in which typhoid bacilli had been found in a pericardial effusion.

J. D. ROLLESTON.

Cardio-sphygmographic observations in typhoid fever (*Jahrb. f. Kinderheilk.*, 1911, lxxiv, p. 386).—**W. Schlieps** examined one hundred children with typhoid fever in the Strassburg Clinic, and thus summarises his results: (1) The well-marked dirotism observed in adults does not

occur in children under fourteen years. (2) Bradycardia is almost invariable at the beginning of convalescence. (3) The frequently observed arrhythmias are due to sinus irregularities. Their prognosis is good, and no special treatment is required. (4) No other kinds of arrhythmias were observed.

J. D. ROLLESTON.

Typhoid fever complicated by double parotitis (*New York Med. Journ.*, 1911, I, p. 176).—R. E. Coughlin records a case in a girl, aged 13 years, who presented all the signs and symptoms of acute appendicitis. An exploratory operation showed the appendix firmly bound down by adhesions and enlargement of the mesenteric glands suggesting typhoid fever or peritoneal tuberculosis. Widal's reaction was positive. Eight days after the operation left parotitis and two days later right parotitis developed. The inflammation in the glands subsided without suppuration. The typhoid fever ran a typical course, accompanied by repeated intestinal hæmorrhages which are uncommon in children. Complete recovery took place after an illness of ninety-seven days.

J. D. ROLLESTON.

A case of nephro-typhoid (*Bull. et Mém. de la Soc. Méd. des Hôp. de Paris.*, 1911, xxxi, p. 51).—C. Lesieur.—A girl, aged 13 years, had a moderate attack of typhoid fever, the onset of which was accompanied by symptoms of nephritis (headache, nephralgia, hæmaturia, enlargement and tenderness of the left kidney). Finally recovery took place.

J. D. ROLLESTON.

Post-typhoid delirium (*Arch. of Ped.*, 1911, xxviii, p. 369).—A. Baines records two cases in boys each aged 6 years, who, some days after the temperature had become normal, developed violent screaming attacks which persisted for four weeks in the one case and about a fortnight in the other. Both ultimately made a complete recovery.

J. D. ROLLESTON.

Vaccine treatment of a typhoid bacillus carrier (*Med. Record*, 1911, II, p. 46).—W. Brem and F. C. Watson.—A girl, aged 4½ years, had typhoid fever in August, 1910. She was given hexamethylenamine for two weeks during convalescence. Shortly afterwards her father and mother developed typhoid. On December 10 and afterwards numerous typhoid bacilli were found in the child's urine. The stools were negative. She was vaccinated nine times with autogenous vaccines between December 10, 1910, and February 1, 1911. The doses were gradually increased from 25 to 1500 millions. The bacilli gradually decreased, and on February 15 the cultures were negative.

J. D. ROLLESTON.

Gangrene in typhus (*Jahrb. f. Kinderheilk.*, 1911, lxxiv, p. 467).—W. Ivanoff records six cases, one of which occurred in a boy, aged 12 years, who was admitted to hospital with gangrene of the leg. Recovery followed amputation.

J. D. ROLLESTON.

Malaria in early infancy (*Cleveland Med. Journ.*, 1910, ix, p. 879).—F. Beekel records a case of quartan type in a male child aged 10 weeks, in whom improvement followed the exhibition of quinine. The source of infection was not known. The child had not been bitten by mosquitoes and no case had occurred in the immediate neighbourhood. Possibly there may

have been intra-uterine infection, as both parents had suffered from malaria, though they had been free of symptoms for some years (*cf.* BRITISH JOURNAL OF CHILDREN'S DISEASES, 1910, VII, p. 180). J. D. ROLLESTON.

Gangrene in infectious disease (*Hospitalstidende*, 1911, LIV, p. 832).—K. N. Andersen records two cases: (1) A girl, aged 5 years, in the fifth week of a mild attack of scarlet fever developed extensive gangrene of the right leg and superficial gangrenous patches of the right thigh and left hip. Recovery took place after amputation through the right knee-joint. A sterile thrombus was found in the popliteal vein. The popliteal artery was normal. (2) A boy, aged 6 years, shortly after an ordinary attack of measles developed gangrenous patches on the buttocks, left thigh and left elbow. Recovery occurred in the course of a month without operation. In neither case was there any cardiac lesion to justify the diagnosis of embolism. The cause of the gangrene was therefore an autochthonous vascular lesion.

J. D. ROLLESTON.

Obscure fever in children (*Thèses de Paris*, 1910-11, No. 29).—P. M. L. Doucet discusses the origin of prolonged subfebrile states in children. Certain diseases, *e.g.* endocarditis, typhoid fever, non-tuberculous adenitis, pyelonephritis, appendicitis, pleurisy, and influenza may run a latent course in children, but their diagnosis is usually settled in a few weeks at most. In the following cases the fever is more persistent, and its origin more likely to escape notice: (1) Digestive auto-intoxication. The temperature usually ranges between 99.4° and 101.4° F. in the evening and normal in the morning, but occasionally rises to 104° F. Sometimes the inverse type is met with. (2) Rhino-pharyngeal inflammation. The patients are the subjects of adenoids, chronic pharyngitis or tonsillitis. Most have had suppurative otitis or otalgia. The pyrexia may last for months or years. Recovery is the rule. The temperature is usually subfebrile, and its course is very variable, being little affected by antipyretics. (3) Tuberculosis, especially of the lymphatic glands. (4) Post-infective states, especially those following influenza. In all these cases the nervous system plays an important part, so that those conditions are most frequently found in neuropathic or arthritic children.

J. D. ROLLESTON.

The influence of the neuropathic and psychopathic constitution on febrile diseases (*Monatsschr. f. Kinderheilk.*, 1911, x, p. 247).—R. Lederer distinguishes two large groups of children according as the members of each react to infection with diminished or increased excitability. In the one group are the children who become apathetic, are almost always asleep or in a state of stupor; in the other are those who have convulsions at the onset, are restless, continually crying and do not sleep. Neuropathic children during an infectious disease require special care and the prognosis should be guarded, as Czerny pointed out (*vide* BRITISH JOURNAL OF CHILDREN'S DISEASES, 1907, IV, p. 312). Seven illustrative cases are recorded. J. D. ROLLESTON.

Dermatology and Syphilis.

Cutaneous diphtheria (*Virchow's Archiv*, 1911, ccv, p. 452).—A. Reinhardt in addition to eleven cases from literature records a fatal case of his own in a girl, aged 9 months, who had been ill for several months with rhino-pharyngitis. Some weeks before death an eczematous condition

of the skin followed by ulceration and necrosis developed. A diagnosis of syphilis was at first made. Virulent diphtheria bacilli were found in the nose, pharynx, tonsils, larynx, trachea, large bronchi, conjunctivæ, and the skin lesions. The latter were chiefly due to auto-inoculation, and possibly also to the clothing and washing.

J. D. ROLLESTON.

Impetigo contagiosa corporis ('*Prag. med. Woch.*,' 1911, xxxvi, p. 297).—**Kraus** showed a boy, aged 12 years, whose body was almost all covered with vesicles filled with cloudy serous fluid, some with crusts, others still moist. The child had been under observation for one week and the vesicles had been appearing and spreading over the body. It is rather unusual for impetigo contagiosa to spread to the trunk; here it has to be diagnosed from pemphigus. The disease is never seen in old people, rarely in the middle-aged, whilst it is very common in children.

M. D. EDER.

Favourable effect from residence in a high altitude in eczema of sucklings ('*Journ. de Méd. de Paris*,' 1911, xxxi, p. 551).—**Prof. Marfan** quotes thirteen cases of this complaint in sucklings, greatly improved by residence in an altitude of 1000–1500 metres. He considers a sojourn of a month to six weeks is sufficient. At the commencement aggravation of the malady may occur, but no change in residence should be made for a week, but if after that improvement does not set in or the child suffers from insomnia, it is necessary to return to the plains. The usual remedies, dietetic, tympanic, and medicinal, should receive attention.

F. R. B. ATKINSON.

Gangrene of vulva ('*Jahrb. f. Kinderheilk.*,' 1911, lxxiii, p. 231).—**Rach** showed a well-developed baby, aged 6 months, with symmetrical gangrene of the labia. The disease had begun four days previously as a vesicle. The child had had no infectious disease. In addition to Gram-positive cocci numerous spirochætes and fusiform bacilli were present in the smear.

J. D. ROLLESTON.

Cutaneous sarcomatosis in children ('*Ann. de Derm. et de Syph.*,' 1911, V^e sér. II, p. 340).—**W. Dubreuilh** records five personal cases and reviews the literature. The condition is usually congenital or appears in the first weeks or months of life. It is then very rarely met with before the age of five or six years. Two types may be distinguished: infantile sarcomatosis properly so called, and the sarcomatosis of late childhood which is allied to that of adolescence or adult life. The growths may be single or multiple. In the former case operation has been successful. The tumour is usually round-celled, but is sometimes spindle-celled as in angio-sarcoma.

J. D. ROLLESTON.

Bromide rash in a suckling ('*Zentralblatt. f. Kinderheilk.*,' 1911, xvi, p. 253).—**G. Čech** narrates the above case in a child, aged 9 months, who had been treated as necessity required with bromide of soda, and had taken from May to January 40 grm. of the drug. In December the rash made its appearance. [Apparently the same case is described, though in greater detail and with a review of the literature, by Prof. F. Scherer in '*Monatsschr. f. Kinderheilk.*,' 1911, x, p. 195.—ED.]

F. R. B. ATKINSON.

Granulosis rubra nasi ('*Prag. med. Woch.*,' 1911, xxxvi, p. 297).—**Kraus** showed to the Verein Deutscher Ärzte in Prague a child, aged 10

years, with an affection of the skin of the nose. The child was badly developed and was rickety. It had had pneumonia, enteritis, and pleurisy. In the last three months there was anorexia, headache, occasionally cough and great sweating of the nose. The urine was normal. The trouble with the nose was of four years' standing. The tip of the nose and the skin over the nostrils were extraordinarily red, with tiny red pimples, vesicles or commencing pustules. On pressure the pimples disappeared. There was a continual hyperidrosis from the affected part. Absence of characteristic nodules, the tuberculin reaction, tendency to infiltration and ulceration, differentiated the condition from lupus vulgaris. Lupus erythematosus, acne vulgaris, acne rosacea were also excluded. Granulosis rubra nasi was first observed by Jadassohn in 1901, who gave a history of seven cases. Its ætiology is unknown. The disease is very chronic; no remedies have been of the slightest use, but it seems to disappear in the course of time. In the discussion it was suggested that the case belonged ætiologically to the cases of dysidrosis manus described by Tilbury Fox, but Kraus maintained that his case was differentiated from other hyperidrotic processes both by its definite clinical characters and its anatomical condition.

M. D. EDER.

Recurrent herpes of buttock ('*Brit. Journ. Derm.*,' 1911, xxiii, p. 322).—**H. G. Adamson**.—Recurrent herpes, which usually affects the face or genitals, may attack other parts, *e. g.* the fingers, as recently recorded by the writer (*vide* BRITISH JOURNAL OF CHILDREN'S DISEASES, 1910, vii, p. 229). He now publishes three cases of recurrent gluteal herpes, one of which occurred in a boy, aged 7 years, who had had several attacks of herpes labialis and had twice before had a similar eruption, though not so large, on the same (right) buttock. Migraine, gout, gravel and nervous troubles are common as personal or family antecedents in this variety of herpes (Dubreuilh), but the family history in the present case was negative.

J. D. ROLLESTON.

A report on 700 cases of tinea capitis ('*Brit. Journ. Derm.*,' 1911, xxiii, p. 330).—**H. M. Scott**.—Of 700 cases seen at the Dermatological Clinic of the London Hospital 628 were examples of microsporon and 72 of endothrix; 405 were boys, 295 girls, the microsporon being relatively commoner in boys. The commonest ages at which the children were brought to hospital were the sixth, seventh, and eighth years. In most cases the disease had been first noticed in the routine examination of school children, in others it had been present for two years or more. X-ray treatment was employed. Nearly 3000 cases of tinea capitis have been treated at this clinic by X-rays without a single case of permanent alopecia. After-treatment consisted in washing once a week till the hairs began to fall, and then in daily washing followed by the application of ung. hydrarg. ammon. dil.

J. D. ROLLESTON.

The frequency of alopecia areata at different ages ('*Ann. de Derm. et de Syph.*,' 1911, V^e sér. II, p. 349).—**R. Sabouraud**.—Among 200 cases, 130 of which were males and 70 females, none occurred before four or after fifty-eight years. It was most frequent between six and eleven years. After twelve years its frequency diminished.

J. D. ROLLESTON.

Mongolian blue spots ('*Bull. et Mém. de la Soc. Méd. des Hôp. de Paris*,' 1911, xxxi, p. 750).—**J. Comby** and **Labourdette** showed a

female child, aged $17\frac{1}{2}$ months, brought to hospital for rickets. Unlike the last case recorded by Comby (*vide BRITISH JOURNAL OF CHILDREN'S DISEASES*, 1911, VIII, p. 283), which presented only one patch, three spots were present. They were of slate-blue colour, and were situated in the lower part of the lumbar region. The child had dark hair and eyes, and the skin was of a uniformly yellowish tint. The parents, who were both of dark complexion, were natives of La Creuse, and had another child whose skin was very white and had no blue patches.

J. D. ROLLESTON.

Mongolian blue spots ('*Thèses de Paris*, 1911-12, No. 44).—**M. Testard**.—These are situated on the extensor surface, usually in the sacral region. As a rule they are multiple and of variable form and extent. They appear at birth or in the first few months of life, remain distinct for some years, and then gradually fade, with very rare exceptions entirely disappearing at the age of six years. Their colour is due to the presence in the dermis of large stellate or fusiform cells full of pigment, which is more abundant at the periphery than at the centre. The cells are derived from the endothelium of the capillaries and the pigment from the blood. The spots are very frequent, not only in yellow races, but also in all living near the Pacific. In white races, on the other hand, they occur with a frequency of only 1 in 300. The thesis contains a record of twenty-nine cases.

J. D. ROLLESTON.

Ætiology of erythema nodosum ('*Deut. Arch. f. klin. Med.*, 1911, CIV, p. 272).—**O. Brian** records ten cases of erythema nodosum. None showed clinically any signs of active tuberculosis, and in only one case did the blood infect a guinea-pig with tuberculosis (*vide BRITISH JOURNAL OF CHILDREN'S DISEASES*, 1910, VII, p. 137). Typical acute rheumatism was not found in any case. Joint affections occurred in about half the cases but were relatively insignificant. Cultures from the blood and joints were sterile and inoculation of the blood did not produce any joint affections in rabbits. Five patients had some throat affection, and five had none. Brian concludes: (1) The ætiology of erythema nodosum is complex. (2) Tuberculosis is by no means the only cause of erythema nodosum, but probably accounts for only a minority of the cases. (3) Acute rheumatism is the cause of only a portion of the cases. The supposition that every erythema nodosum is a rheumatic infection is unfounded. (4) The throat is the portal of entry in many cases, but not in all.

J. D. ROLLESTON.

Erythema nodosum ('*L'Echo Méd. du Nord*, 1911, xv, p. 401).—**A. Deleârde** and **G. L. Hallez** review the literature of this subject, which has been recognised from antiquity and was named by Willan in 1798. It was well described by Schönlein in 1829. Hebra considered it a rheumatic manifestation, but later Trousseau regarded it as a morbid entity, akin to an eruptive fever. Landouzy regarded it as a tubercular manifestation, at least in some cases, and more recently others have supported this view from laboratory experiment and the results of the skin reaction to tuberculin. Erythema nodosum may come on in the course of various other diseases, but quite as frequently it appears without any cause, like an eruptive fever. It is rare in infants, but common in older children. It is more than twice as frequent in girls as in boys. Climate and season seem to have no influence. It is rare to find evidence of tubercle, but the cuti-reaction is very frequently

positive, suggesting what Laudouzy called "an attenuated bacillary septicæmia." The arthralgia is not attended by swelling. With regard to pathogenesis, some cases begin in healthy children like an eruptive fever, and others are seen in the course of infections, either acute, such as diphtheria, typhoid fever, strepto- or meningococcal infections or acute rheumatism, or chronic, such as malaria, syphilis or tubercle. With regard to those apparently primary it is suggested that they are a manifestation of tubercular infection. In a large number of cases evidences of tubercle appear within a few months, and in others tuberculosis is present at the same time. Von Pirquet's reaction is often positive, and the injection of tuberculin gives the characteristic reaction, but the bacillus has never been obtained from the lesions. The authors then conclude that erythema nodosum is frequently an evidence of a concealed tuberculosis and the lesions are produced by the toxins of this organism.

J. PORTER PARKINSON.

Changes in the umbilical cord in syphilis (*Riv. di. Clin. Pediat.*, 1911, ix, p. 613).—**M. Dominici** has made careful researches on the cords in seven cases. He finds them in the majority of cases thickened to about double the normal size. The lesions are most marked at the placental end; this is important with regard to the theory of the placental transmission of syphilis. He does not share the opinion of Bondi, Ziegler and others, who hold that the gumma alone is the evidence of specific lesion. He found numerous treponemata in cases where there were neither gummatous nodules nor gummatous infiltration with necrosis; hence the spirochætes, besides causing specific lesions, can also produce inflammatory processes. In one case, besides perivascularitis, there were gummatous nodules in an artery with intense necrosis. Slight structural changes were met with in some cords. In one of a fœtus that died immediately after birth, and whose mother was undoubtedly syphilitic and had a positive Wassermann reaction, there was no trace of recent or old inflammation. A disturbance in growth produced by toxins is often the only explanation. In another case there was hyperplasia of the internal muscular layer and sclerosis, probably inflammatory. In another there was thickening of the walls of the veins. There were also decided changes in the elastic fibres. The specific organism is almost always to be found in the umbilical cords of syphilitic fœtuses—an important fact as regards treatment and the prevention of transmitting the disease to a healthy infant perhaps suckled by the same wet-nurse.

VINCENT DICKINSON.

Chancre of scalp in an infant (*Berlin. klin. Woch.*, 1911, XLVIII, p. 792).—**L. Weiss** could find only twenty-one cases of chancre of the scalp on record, including the following personal one: An infant whose mother had contracted syphilis five years previously, and in whom Wassermann's reaction was still feebly positive, developed two hard chancres close to one another on the scalp three weeks after birth. Spirochætes were found in the lesions. A few weeks later a maculo-papular eruption appeared first on the face and then on the trunk and limbs. Rapid disappearance of the symptoms followed sublimate injections. The source of infection was not clear, as the mother, who had undergone several inunction cures, did not present any lesions. The case is a remarkable exception to Profeta's law, inasmuch as the child was not immune in spite of the mother being syphilitic.

J. D. ROLLESTON.

Syphiloma of the tongue in a girl (*Arch. de Méd. des Enf.*, 1911, xiv, p. 288).—**Comby** and **Schreiber** report a case of sclerous glossitis in a girl, aged 6 years, a lesion of rare occurrence in children. In the middle of the dorsal surface of the tongue was a slightly raised patch, the size of a shilling. The surface was denuded of epithelium, with a deep transverse fissure in the centre. The margin of the lesion was sharply defined by a furrow, except at the posterior part, where a narrower prolongation merged with the rest of the tongue. On palpation the lesion was found to be considerably indurated. In addition to this lesion, the tonsils were much enlarged and of a lardaceous appearance; right tonsil presented a deep fissure. Adenoid vegetations were also found. At the left commissure of the lips was a mucous patch. Typical Hutchinson's teeth were not present, but the upper median incisors presented multiple erosions; the lower incisors similar erosions, but less marked. Wassermann's reaction was positive in mother and child. The authors regard the lesion of the tongue as a tertiary syphiloma, belonging to the class of insular cortical glossitis.

C. F. MARSHALL.

Syphilis and congenital mental defect (*Journ. Ment. Sci.*, 1911, LVII, p. 499).—**C. G. A. Chislett**.—Few acute cases of infantile syphilis show changes in the central nervous system on post-mortem examination; on the other hand, Heubner found that of 230 idiots, fifty had syphilitic parents. Wassermann's reaction was performed on fourteen idiots or imbeciles; eight of those gave a positive reaction, only two showed pegged teeth, but 5 showed bossing of the forehead and depressed nasal bones. Five cases had internal or external squint, and of these as many as four gave a positive Wassermann. Two cases of juvenile general paralysis in girls aged 8 and 13 years, afforded positive reactions both with blood and cerebro-spinal fluid; one of them developed deafness and keratitis. Of three epileptic imbeciles one was positive, and of three paralytic idiots all were negative. The family of a general paralytic were examined. The father and patient, his wife, and three of their six children reacted positively to the Wassermann test. The eldest child was a boy, aged 16 years, who was nervous and stupid at school but presented no definite signs of the disease; the second was a girl, aged 12 years, deaf in one ear; and the third, a boy, aged 8 years, had rhinitis and conjunctivitis. The author concludes that syphilis plays a larger part in the causation of mental affection than is generally supposed.

CHRISTOPHER ROLLESTON.

Wassermann's reaction in the new-born (*Lyon. Méd.*, 1911, cxvii, p. 112).—**M. Pillon** communicated to the Soc. de Méd. de Lyon the results of Wassermann's reaction made in twenty-two new-born children. In Group 1, where from clinical facts it was impossible to affirm or even suspect the existence of syphilis, out of seventeen children the reaction was negative twice and positive fifteen times. In Group 2 where syphilis was clinically certain or probable, out of five children the reaction was positive four times and negative once. In this last case the mother was undoubtedly syphilitic; the infant had never been treated, presented no signs of syphilis and grew normally.

VINCENT DICKINSON.

The Wassermann reaction in hereditary syphilis (*Cleveland Med. Journ.*, 1911, x, p. 291).—**R. Dexter** and **C. Cummer** obtained 88.2 per cent. of positive reactions in cases of congenital syphilis with obvious

symptoms. They remark that the reaction has shown that Colles's law must be revised, or interpreted in another way. Examination of the mothers of congenitally syphilitic children, who have themselves no symptoms, has shown that many of them have latent syphilis. They conclude that the test is an aid to clinical observation, but can never supplant it; also, that the results should be interpreted by one who has experience both of the clinical and the serological sides of the question. **W. C. Stoner** (*ibid.*, p. 307) found ten positive reactions out of seventy-five cases of imbecility, cretinism, idiocy and feeble-mindedness, in none of which could a history of syphilis be obtained.

C. F. MARSHALL.

Hereditary syphilis and the Wassermann reaction (*Arch. of Pediat.*, 1911, xxviii, p. 484).—**M. S. Reuben** begins his interesting paper with an account of the history of the most important discoveries in syphilis, and an excellent explanation of Wassermann's reaction. The sperm rarely infects the ovum. Usually infection is carried from the mother by the placenta, so that if the infant is syphilitic the mother is so too, though she may show no signs, in fact 90 per cent. of the parents who have congenitally syphilitic children give a positive Wassermann. Statistics from other authors are quoted to show that the percentage of mothers who react positively to Wassermann's test is the same as that given by women in the early latent stage of the disease. The greater the number of children born to one woman, and the longer the period of time elapsed since the birth of the last syphilitic infant, the less likely is the Wassermann to be positive. Profeta's law that children born to syphilitic parents are to a certain extent immune to the disease is proved to be untrue, for 90 per cent. of such children give a positive Wassermann. If treatment is begun early 75 per cent. of syphilitic children give a negative reaction within one month, but if treatment is neglected for six months only 33 per cent. Potassium iodide, atoxyl, and soamin have no influence on the reaction; "606" brings about a negative result in a period varying from two to six months. The author says that neither mercury nor "606" cure syphilis, but simply transform an active into a latent form of the disease. Infantile mortality is seriously affected by syphilis: only 5 per cent. of the conceptions of syphilitic women result in children who survive the first year of life.

CHRISTOPHER ROLLESTON.

Wassermann's reaction in the blind, deaf-mutes and epileptics (*Hospitalstidende*, 1911, liv, p. 343).—**O. Thomsen** and **W. Leschly**.—The investigation was made in the State Serum Institution in connection with a previous inquiry (*vide* BRITISH JOURNAL OF CHILDREN'S DISEASES, 1911, viii, p. 284) with the following results. Among 146 blind persons whose ages ranged from 5 to 20 years not a single one gave a positive reaction; out of 344 deaf-mutes aged from 5 to 40 years only three reacted positively, among 259 epileptics from 5 to 70 years only one was positive. The writers conclude that inherited syphilis does not play a greater part in the ætiology of these affections than has hitherto been supposed.

J. D. ROLLESTON.

Salvarsan in sucklings (*Berlin. klin. Woch.*, 1911, xlviii, p. 511).—**Döblin** reports six cases of sucklings injected subcutaneously with salvarsan. Four of the six infants died—half a day, one day, four days, and three and a half weeks respectively after injection. The dose injected varied from 0.025 to 0.06 grm. Two infants who survived the injection improved as regards their skin eruptions, but one relapsed, and

there was no effect on the glandular swellings or rhinitis. Two of the fatal cases were in good condition and two in bad condition before injection. In one of the fatal cases, a well-nourished infant which died four days after an injection of 0.03 grm., the autopsy revealed acute oedema of the subcutaneous tissue and mesenteric glands, signs suggestive of arsenical poisoning. In the fatal cases no spirochaetes were found in the liver. [It was originally claimed for salvarsan that it killed the spirochaetes; this may be true in the cases where it also kills the patient.—C. F. M.] C. F. MARSHALL.

Salvarsan in congenital syphilis (*Jahrb. f. Kinderheilk.*, 1911, LXXIII, p. 730).—**Hochsinger** reported two cases: (1) A well developed breast-fed child, aged 10 months, showed a papular rash and a diffuse infiltration of the soles. Within a week of an injection of 0.08 salvarsan the symptoms disappeared. Seven weeks after the injection there was a relapse of a macular character affecting the face and soles. (2) A hand-fed child, aged 7 weeks, showed Parrot's pseudo-paralysis and coryza. Five days after an injection of 0.07 salvarsan it could move its arms again. Hochsinger proposed to re-inject the cases. No bad effects were noticed, but only a slight febrile reaction of one day's duration. J. D. ROLLESTON.

Salvarsan in the syphilis of children (*Wien. klin. Woch.*, 1911, XXIV, p. 583).—**J. von Bokay, L. Vermes, and Z. von Bokay.**—Twenty-six children, twenty-three with congenital and three with acquired syphilis, were treated with salvarsan. Their ages ranged from 0–11 years. Thirteen were under one year, but were fairly well developed and breast-fed. Intra-gluteal injections were given in every case but one, in which a sub-costal injection was given owing to dermatitis of the buttocks. The intravenous method was not employed. In only one case was the indirect method used; *i.e.* injection of the mother who showed definite symptoms of syphilis. In this case a marked Herxheimer's reaction occurred in the child a week after the mother's injection and did not entirely fade until a direct injection had been given. Second injections were given when the symptoms were slow in clearing up and Wassermann's reaction continued positive. As a rule it became negative by the sixth or eighth week from injection. In three cases relapses occurred. High fever was hardly ever seen, but only a slight increase of pre-existent fever. In every case but one a rapid increase in weight occurred as the result of treatment in marked contrast to the slow increase which follows the use of mercury. Salvarsan had a rapidly curative effect on the maculo-papular rash, condylomata, osteo-chondritis, paronychia, coryza, and parenchymatous keratitis. In conclusion, the writers recommend salvarsan in preference to mercury for breast-fed children in good condition, but add that time will show whether the effect will be durable. J. D. ROLLESTON.

Salvarsan in syphilis of children (*Journ. Amer. Med. Assoc.*, 1911, I, p. 405).—**L. Fischer** records three cases in children aged 18 months, 6 years, and 8 years. The immediate result in each case was marked improvement as regards the effect on the visible gummata and condylomata, but in the youngest child the intra-gluteal injection of 0.3 grm. was followed by symptoms of toxic neuritis. Fischer thinks the symptoms may have been due to idiosyncrasy, but he regards the dose given as too large and recommends 0.1 grm. for future injections. He strongly deprecates the injection of ambulant patients with salvarsan. J. D. ROLLESTON.

Review.

MALADIES DES Os, par MARFAN, professeur à la Faculté de médecine de Paris, APERT, AVIRAGNET, L. BERNARD, M. GARNIER, J. HALLÉ, MILIAN, médecins des hôpitaux de Paris. 1 vol. gr. in-8 de 755 pages avec 164 figures. Broché: 15 fr. Cartonné: 16 fr. 50. (Librairie J.-B. BAILLIÈRE ET FILS, 19, rue Hautefeuille, à Paris.) 1912.

THIS authoritative work, which forms the 39th fasciculus of 'Le Nouveau Traité de Médecine et Thérapeutique,' edited by Professors Gilbert and Thoinot, deals with diseases of bones, both in adults and children, from a medical point of view, and thus is complementary to Maucclair's fasciculus in 'Le Traité de Chirurgie,' edited by Professors Le Dentu and Delbet. The line between medical and surgical affections of bone is perhaps rather uncertain, for while this volume does not deal with fractures or malignant disease of bone, it describes osteomyelitis, osteitis, and multiple exostoses. The important subject of rickets is fully and originally treated by Professor Marfan in an article of 250 pages, which will serve as a valuable source of reference for many years. The same author gives an account of Barlow's disease (infantile scurvy), which appears to have been first described by Monfalcon in 1820, then as "acute rickets" by Möller in 1859, and in 1871 by a Danish physician, Ingerslav, who regarded his case as one of scurvy in a baby. The name "Barlow's disease" was suggested by Heubner. Milian gives a good account of syphilitic bone and joint disease, in which due attention is paid to the manifestations in early life. The more obscure and rarer forms of bone disease are clearly dealt with, and provide extremely interesting reading. As already hinted, this volume is a valuable and trustworthy source of reference.

H. D. ROLLESTON.

Correspondence.

NATIONAL ASSOCIATION FOR THE PREVENTION OF CONSUMPTION.

To the Editor of THE BRITISH JOURNAL OF CHILDREN'S DISEASES.

DEAR SIR,—The Council of the Association would be grateful if you would kindly allow a notice to the following effect to be inserted in your valuable JOURNAL:

The Association is actively engaged in forming a library and bureau for the collection of all matters relating to pulmonary tuberculosis from every point of view, and in all countries. It is intended that such information shall be available not only to members of the medical profession but to the public at large. Valuable assistance would be rendered if medical officers of health, school medical officers, and medical superintendents or secretaries of hospitals, sanatoria, tuberculosis dispensaries, and open-air schools would kindly place the Association on their distribution list in respect of annual reports or other documents bearing on the question of consumption. Books, pamphlets, and reprints of articles from physicians and social workers in general would also be gladly received.

Believe me,

20, Hanover Square,
London, W.

December 16, 1911.

Yours very truly,

J. J. PERKINS,

Hon. Secretary.